

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME FIRST MIDDLE LAST HERMAN FOX | | | | JANUARY 27, 1986 | | | |
| 3. SEX MALE | | | | 4. RACE WHITE | | | |
| 5. DATE OF BIRTH MONTH DAY YEAR MAR. 8, 1901 | | | | 6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4008 FALLSTAFF RD. (21215) | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MERCHANT | | | | 12b. KIND OF BUSINESS OR INDUSTRY RETAIL | | | |
| 13a. STATE MARYLAND | | | | 13b. COUNTY | | | |
| 13c. CITY OR TOWN BALTIMORE | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 13e. STREET ADDRESS / ZIP CODE 4008 FALLSTAFF RD. #21215 | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST SABATAI FOX | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HODA ADES | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 220-32-0287 | | | |
| 17. INFORMANT MRS. NATALIE JEFFREY | | | | 4008 FALLSTAFF RD. BALTO., MD 21215 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Angiomyeloid blastoma lymphadenopathy</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>6 MONTHS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>6/19</u> 19 <u>81</u> to <u>1/27</u> 19 <u>86</u> that (I) (we) last saw the deceased alive on <u>1/21</u> 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Boris Kerzner</u> | | | | 22c. DATE SIGNED 1/27/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BORIS KERZNER | | | | 22e. ADDRESS 131 SLADE AVE (21208) | | | |
| 22f. NAME OF CEMETERY OR CREMATORY ARLINGTON (CHIZUK AMINO) | | | | 22g. LOCATION BALTIMORE COUNTY MARYLAND | | | |
| 22h. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 22i. DATE JAN. 28, 1986 | | | |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTIMORE, MD. (21215) | | | | 25a. DATE REC'D. BY REGISTRAR JAN 29 1986 | | | |
| 25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u> | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL COMMANDING PHYSICIAN, The law requires that the death certificate be executed within 24 hours after death, and that it may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR, After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

20% COTTON FIBER

WILSON & CO. INC.



029013

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|---|--|---|---|---|---|--|--------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | | |
| FIRST MIDDLE LAST FERDINAND Lawrence FRANK | | | MONTH DAY YEAR January 24, 1986 | | | 1:15P.M. | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| Male | | white | | MONTH DAY YEAR 10-5-02 | | 83 YRS | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Md. | | U.S.A. | | | | Baltimore MD. | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | | Maryland General Hospital | | | | Interior Decorator | | | | |
| 13a. STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE | |
| Md. | | | | | in Balto. | | | | 3803 Elkader Rd. 21218 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | |
| Joseph Frank | | | | | Margaret Holtzhide | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| No | | | 217-01-7469 | | Margaret E. Frank, Same as 13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adult Respiratory distress syndrome DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral vascular accident | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-22-86 | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from January 9, 1986 , to January 24, 1986 , that (I) (we) last saw the deceased alive on January 24, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <i>Rebecca Byrd</i> | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rebecca Byrd, M.D. | | | | | 22e. ADDRESS c/o Maryland General Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | | 1-28-86 | | Moreland | | Balto., Md. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | | | | |
| Leonard J. Ruck, Inc., 5305 Harford Rd. | | | | | JAN 21 1986 | | | | | |

MEDICAL CERTIFICATION

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BP

TO HOSPITAL CERTIFYING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in (including funeral director's page 3) should be detached for use as the burial-transit permit. Then please remove coroner's pages, pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1- STATE
REGISTRARSTATE OF MARYLAND 8 6
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) ALBERT E. FRANUS | | | 2a. DATE OF DEATH MONTH 1 DAY 22 YEAR 86 | | | 2b. HOUR 1205 PM | | | | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH 5 DAY 22 YEAR 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 72 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Inspector | | 12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Dundalk | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 3 Graywood Road 21222 | | | |
| 14. FATHER'S NAME FIRST Sebastian MIDDLE LAST Franus | | | | 15. MOTHER'S MAIDEN NAME FIRST Catherine MIDDLE LAST Chicek | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | | 16b. SOCIAL SECURITY NO. WW II 170-09-3183 | | 17. INFORMANT Lillian J. Franus | | | | ADDRESS Same as 13e | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). S/P MYOCARDIAL INFARCTIONS | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/22 , 19 86 , to 1/22 , 19 86 , that (I) (we) last saw the deceased alive on 1/22 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Christine C. Harter | | | | DEGREE MD | | | | 22c. DATE SIGNED | | 22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) Christine C. Harter MD | | | | 22f. ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment | | | | 23b. DATE 1/25/1986 | | 23c. NAME OF CEMETERY OR CREMATORY Holly Hill | | 23d. LOCATION CITY OR TOWN COUNTY STATE White Marsh Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue Dundalk, Maryland 21222 | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE JAN 24 1986 | | | |

BP

ALBERT E. FRANZ

WHITE

MALE

BALTIMORE CITY

RECEIVED



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) JOHN SIO GREENE FEARER | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 15 86 | | 2b. HOUR 8 P M |
| 3. SEX F | 4. RACE B | 5. DATE OF BIRTH MONTH DAY YEAR 7 14 09 | 6. AGE (IN YEARS LAST BIRTHDAY) 76 | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pikesville - S.C. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LUTHERAN HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY At Home | |
| 13a. STATE MD | | 13b. COUNTY Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 1411 N ROSDAL ST 21216 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOHN GAFFIN | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE Beile Henderson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 212-30-6238 | 17. INFORMANT ADDRESS MINNIE McDONNELL 2733 W. WINDSOR ST | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) 2 yr to ASCVD. and Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) Aortic Insufficiency | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH + 3 days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11 | | | | | |
| 19a. DATE OF OPERATION 1/15/86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 11 | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/5/80 , 19 86 , to 1/15 , 19 86 , that (I) (we) last saw the deceased alive on 12/10 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE John S. Green | | DEGREE MD | | 22c. DATE SIGNED 1-20-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. GAKUBA | | 22e. ADDRESS 600 Reisterstown Rd Pikesville Md 21208 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (CHECK) BURIAL | 23b. DATE 1/22/86 | 23c. NAME OF CEMETERY OR CREMATORY MD Nat. Mon. Pk | | 23d. LOCATION CITY OR TOWN COUNTY STATE Lanham MD | |
| 24. FUNERAL DIRECTOR NAME Manly & Son 638 N. G. Ave | | | 25a. DATE REC'D. BY REGISTRAR JAN 22 1986 | | |
| 25b. REGISTRAR'S SIGNATURE John S. Green | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

034.30

30% COLLOID

WATER

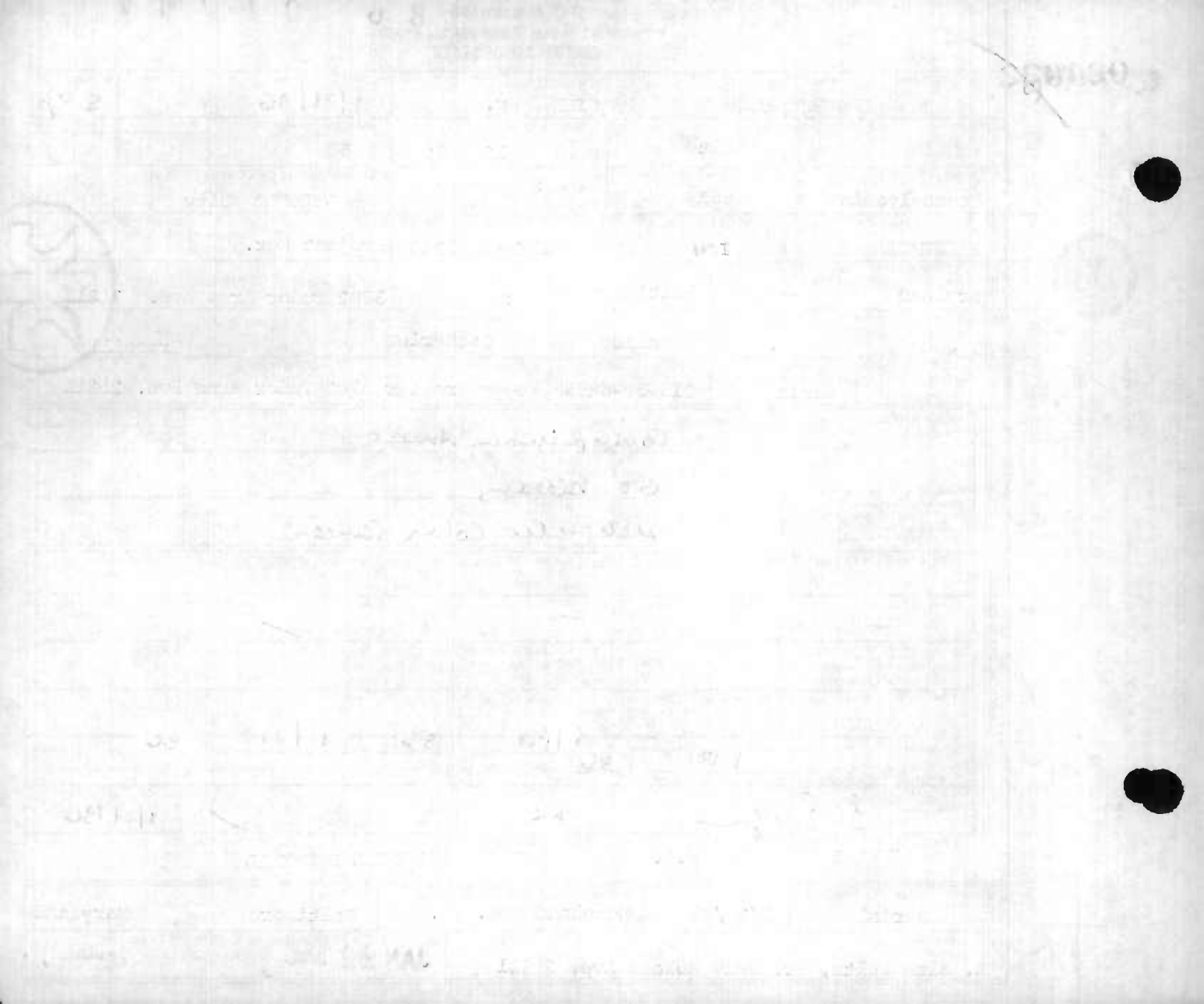


STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|---|---|--------|---|---|-----------------------------------|--|-------------------------------------|----------|
| DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR |
| ROBERT RAYMOND FRAZIER, Sr. | | | | | 11/21/86 | | | | 5 00 PM |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | |
| Male | White | MONTH 10 DAY 12 YEAR 35 | | 50 | MONTHS DAYS | | HOURS MIN. | | |
| BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Pennsylvania | USA | | | BALTIMORE City MD | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| BALTIMORE CITY | UN TON MEMORIAL HOSPITAL 21218 | | | Project Mgr. | | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | |
| Maryland | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 3702 Tudor Arms Ave. 21211 | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | | | | | |
| John E. Frazier | | Catherine Graczilla | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| yes | | Korea | | 215-30-6865 Peggy Frazier 3702 Tudor Arms Ave. 21211 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>GI bleeding</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metastatic Colon Cancer</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | STATE |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/1/86</u> 19 <u>86</u> to <u>1/21</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>1/21</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Sc. G. G.</u> | | | | DEGREE <u>MS</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED <u>11/21/86</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) TIMOTHY TRAGESER, M.D. | | | | 22e. ADDRESS UNION MEMORIAL HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN | | COUNTY | STATE |
| Burial | | 1/24/86 | | Moreland Mem. Pk. | | Baltimore | | | Maryland |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| A. Alan Seitz, Jr. 3818 Roland Ave. 21211 | | | | JAN 22 1987 | | | | | |



017116

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|--|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) Martin ALAN Friedmann | | | 2a. DATE OF DEATH MONTH DAY YEAR Jan 10 86 | | 2b. HOUR 1145 AM |
| 3 SEX MALE | 4 RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR DEC. 8, 1946 | | 6 AGE (IN YEARS LAST BIRTHDAY) 39 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? USA | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10 CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY HOSPITAL | | 12a. USUAL OCCUPATION DEPT. OF HOUSING & COMMUNITY DEVELOP. | | 12b. KIND OF BUSINESS OR INDUSTRY CITY OF BALTO |
| 13a. STATE MARYLAND | | | 13b. COUNTY BALTIMORE | 13c. CITY OR TOWN BALTIMORE | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14 FATHER'S NAME FIRST MIDDLE LAST MILTON P. FRIEDMANN | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERNICE SUGAR | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 213-46-1721 | | 17 INFORMANT MRS. BERNICE FRIEDMANN | |
| | | 2700 SMITH AVE. BALTO., MD | | 21209 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ~ 2 hrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10 Jan 86 19 86 to 10 Jan 86 19 86 that (I) (we) last saw the deceased alive on 10 Jan 86 6 30 P.M. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Carl J. Tonnaso DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 10 Jan 86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CARL TONNASSO MD | | 22e. ADDRESS Univ. Maryland Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 1-12-86 | | 23c. NAME OF CEMETERY OR CREMATORY SHAAREI TFILOH CONG. | |
| | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD | |
| 24 FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. NAME NO. 16 REISTERSTOWN RD., BALTO., MD ADDRESS 21215 | | | | 25a. DATE REC'D. BY REGISTRAR JAN 14 1986 25b. REGISTRAR'S SIGNATURE John L. ... | |

TO HOSPITAL OR FUNERAL HOME: This certificate must be retained by the hospital or funeral home for 24 hours after death. Page 4 may be retained by the hospital or funeral home.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the instructions on the reverse side, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20% COTTON FIBER

MADE IN U.S.A.



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | |
|---|--|--|---|--|----------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) Mrs. Marguerite H. Furlong | | | 2a. DATE OF DEATH MONTH DAY YEAR January 19 1986 | | 2b. HOUR 8:15 PM | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR September 12 1901 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 84 | | 7. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City | | |
| 9. BIRTHPLACE (STATE OR FOREIGN) Maryland | | 10. CITY OR TOWN OF DEATH Baltimore City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Villa St. Michael Nursing Center | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper | | 12b. KIND OF BUSINESS OR INDUSTRY Commerce Dist. | | 12c. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City | | |
| 13a. STATE Maryland | | 13b. CITY OR TOWN Marriottsville | | 13c. STREET ADDRESS / ZIP CODE 7107 Marriottsville Road 21104 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Jacob Schaub | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Galbreath | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | |
| 17. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-12-5552 | | 18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mrs. Mary Catherine McHale | | 19. ADDRESS 7107 Marriottsville Rd. Marriottsville Maryland | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPIRATION PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CONGESTIVE HEART FAILURE | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE Tasneem Lakhani | | DEGREE MD | | 22c. DATE SIGNED 1/28/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) TASNEEM LAKHANI | | 22e. ADDRESS 7220 PARK HEIGHTS AVE BALTIMORE | | 22f. BALTIMORE CITY OR COUNTY OF DEATH Baltimore | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | 23b. DATE 01-22-86 | | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery | | |
| 23d. LOCATION Baltimore | | 23e. COUNTY Maryland | | 23f. BALTIMORE CITY OR COUNTY OF DEATH Baltimore | | |
| 24. FUNERAL DIRECTOR Loring Byers Funeral Directors, Inc. | | 24b. DATE REC'D. BY REGISTRAR JAN 21 1986 | | 24c. REGISTRAR'S SIGNATURE Wanda Davidson | | |
| 24d. ADDRESS 8728 Liberty Road Randallstown, Maryland 21133 | | 24e. BALTIMORE CITY OR COUNTY OF DEATH Baltimore | | 24f. BALTIMORE CITY OR COUNTY OF DEATH Baltimore | | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, death from a traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please temporarily retain it. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | REG. NO. 01052 | |
|--|--|---|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) <u>SKIRLEY (GABRISZEWSKI) (SHIRLEY) Gabrizeski</u> | | | | | 2a. DATE OF DEATH MONTH DAY YEAR <u>1/3/86</u> | |
| 3. SEX <u>F</u> | | | | | 2b. HOUR <u>1:47 P.M.</u> | |
| 4. RACE <u>White</u> | | 5. DATE OF BIRTH MONTH DAY YEAR <u>7 2 49</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>36</u> | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Virginia</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore</u> MD. | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Unemployed</u> | |
| 10. CITY OR TOWN OF DEATH <u>Baltimore</u> | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>FSKMC</u> | | | | | 13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13a. STATE <u>Md</u> | | 13b. COUNTY <u>Baltimore</u> | | 13c. STREET ADDRESS / ZIP CODE <u>1610 Dundalk Ave 21222</u> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <u>Howard</u> | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Ethel</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u> | | 16b. SOCIAL SECURITY NO. <u>220-70-6050</u> | | 17. INFORMANT ADDRESS <u>John F Gabrizeski 1610 Dundalk Ave</u> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac / resp arrest</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <u>hypotension</u> | | | | | 2 days | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>hepatic failure</u> | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>GI bleeding</u> | | | | | | |
| 19a. DATE OF OPERATION <u>Dec 17</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 17</u> 19 <u>85</u> , to <u>Jan 3</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Jan 3</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE <u>Patricia C HKS</u> | | | | DEGREE <u>MD</u> | | 22c. DATE SIGNED <u>1/3/86</u> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>PATRICIA C HKS</u> | | | | 22e. ADDRESS <u>FSKMC 4940 Eastern Ave</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u> | | 23b. DATE <u>1/7/86</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Westview Memorial Park</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Catonsville Md</u> |
| 24. FUNERAL DIRECTOR <u>William C. March F/H West 4300 Wabash Avenue</u> | | | | 25a. DATE REC'D BY REGISTRY <u>JAN 7 1986</u> | | |

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

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|--|--|---|--|---|--|--|--|--|--|----------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) OLGA | | FIRST OLGA | | MIDDLE GALITZINE | | LAST GALITZINE | | 2a. DATE OF DEATH MONTH DAY YEAR 01-24-86 | | 2b. HOUR 8:35 PM | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 10, 1923 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 62 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | 8. IF UNDER 24 HRS | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) France | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) univ of md Hosp | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant | | 12b. KIND OF BUSINESS OR INDUSTRY French Embassy | | | | | |

| | | | | | | | | | | | |
|--|--|------------------------------|--|--------------------------------------|--|---|--|--|--|--|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY Howard | | 13c. CITY OR TOWN Columbia | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 6336 Cedar Line # 313 21046 | | | |
|--|--|------------------------------|--|--------------------------------------|--|---|--|--|--|--|--|

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|--|--|---|--|
| 14. FATHER'S NAME FIRST MIDDLE LAST Alexis Orloff | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Boyer DeGueness | |
|--|--|---|--|

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|---|--|--|--|---------------------------------------|--|--|--|
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) N/A | | 16b. SOCIAL SECURITY NO. 077-24-0370 | | 17. INFORMANT Atty. in Fact | | ADDRESS Alexis Shelokov - 7233 Dockside Lane, Col. Md. | |
|---|--|--|--|---------------------------------------|--|--|--|

| | | | |
|--|--|---|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) massive intracerebral hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days | |
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| | | | |
|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I H/o Cerebrovascular accident | | | |
|--|--|--|--|

| | | | | | | | |
|------------------------|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
|------------------------|--|--|--|--|--|--|--|

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
|--|--|---|--|--|--|--|--|

| | | | | | |
|---|--|--|--|---|--|
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
|---|--|--|--|---|--|

| | |
|--|--|
| 22a. I certify that (I) (this hospital) attended the deceased from 1/22 19 84 to 1/24 19 86 , that (I) (we) last saw the deceased alive on 1/24 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | |
|--|--|

| | | | | | |
|---------------------------------------|--|---------------------|--|------------------------------------|--|
| 22b. SIGNATURE Pat Weber MD | | DEGREE MD | | 22c. DATE SIGNED 1/24/86 | |
|---------------------------------------|--|---------------------|--|------------------------------------|--|

| | | | | | |
|--|--|---|--|--|--|
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAT WEBER M.D. | | 22e. ADDRESS University of Md. Hospital, Baltimore, Md. | | | |
|--|--|---|--|--|--|

| | | | | | | | |
|--|--|------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 2-1-1986 | | 23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C. | |
|--|--|------------------------------|--|--|--|---|--|

| | | | | | |
|--|--|---|--|---|--|
| 24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home Silver Spring, Md. | | 25a. DATE REC'D. BY REGISTRAR IAN 28 1986 | | 25b. REGISTRAR'S SIGNATURE Juanita... | |
|--|--|---|--|---|--|

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be signed within 24 hours after death. This certificate may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2. They should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, this medical examiner must be notified at once.

MEDICAL CERTIFICATION

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| | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|
| FOR 1 - STATE REGISTRAR | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 6 0 1 0 5 4 | | | | | |
| I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST REVA L GAMBRILL | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 / 31 / 86 | | | | 2b. HOUR 10:20 PM | |
| 3 SEX FEMALE | | 4 RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 7 19 30 | | 6 AGE (IN YEARS LAST BIRTHDAY) 54 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | | | | | |
| 10 CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY OF MARYLAND | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR TEST OF WORKING LIFE) Dietician | | 12b. KIND OF BUSINESS OR INDUSTRY Hosp. | | | |
| 13a. STATE MD | | | | | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Benjamin Savage | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Johnson | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 213-62-3510 | | 17 INFORMANT Yvette Wheelhel | | ADDRESS Balto. 21216 Longwood ST | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST SEPSIS DUE TO, OR AS A CONSEQUENCE OF (b) SEPSIS RADIATION THERAPY. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) CERVICAL CANCER APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/19, 1985, to 1/31, 1986, that (I) (we) lost saw the deceased alive on 1/31, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE George F. Tidey MD | | | | DEGREE MD | | | | 22c. DATE SIGNED 1/31/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE F. TIDEY | | | | 22e. ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 2-6-86 | | 23c. NAME OF CEMETERY OR CREMATORY Md National Mem PK | | 23d. LOCATION CITY OR TOWN Laurel | | COUNTY Prince George | | STATE MD | |
| 24 FUNERAL DIRECTOR Turnell B. Oden - 1638 Druid Hill Ave | | | | 25a. DATE REC'D. BY REGISTRAR FEB 1 1986 | | 25b. REGISTRAR'S SIGNATURE Wardson | | | | | |

2025 COLLECTION 2025

UNIVERSITY OF MICHIGAN



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037123

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) CANDELARIA GARCIA | | | 2a. DATE OF DEATH MONTH DAY YEAR 01 31 '86 | | | 2b. HOUR M | | | |
| 3. SEX FEMALE | | 4. RACE CAUC. | | 5. DATE OF BIRTH MONTH DAY YEAR 11 30 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (COUNTRY) SPAIN | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 632 TOLNA STREET | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST MANUEL PAZ GARCIA | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CANDELARIA PAZ HERMO | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 218-62-4472 | | 17. INFORMANT MR. JAMES GARCIA - | | ADDRESS 50 WINDEMERE PKWY. PHOENIX, MD. 21131 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic colon cancer</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>liver failure</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>diaphragmatic hernia</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 1-28</u> , 19 <u>86</u> , to <u>Jan 16</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>1-28</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>W. H. Vriesendorp</u> M.D.; Ph.D. | | | | DEGREE M.D.; Ph.D. | | | | 22c. DATE SIGNED 2-1-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) VRIESENDORP H.M. | | | | 22e. ADDRESS JOHNS HOPKINS ONCOLOGY CENTER 600 N WOLF STREET, NO. 21205 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 2-3-86 | | 23c. NAME OF CEMETERY OR CREMATORY OAK LAWN Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MD. | | | |
| 24. FUNERAL DIRECTOR NAME Walter Dabrowski - 1005 Dundalk Avenue 21224 | | | | 25a. DATE RECD. BY REGISTRAR FEB 04 1986 | | 25b. REGISTRAR'S SIGNATURE <u>John Dabrowski</u> | | | |

MEDICAL CERTIFICATION

2
9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSFERMENT, PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 01056 | |
|--|----------------------|--|---|---|---|---|--|---|--|----------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) JAMES STAFFORD GARDNER | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1-14-86 19 | | 2b. HOUR M | | | |
| 3. SEX M | 4. RACE NEGRO | 5. DATE OF BIRTH MONTH DAY YEAR 3 2 24 | 6. AGE (IN YEARS) (LAST BIRTHDAY) 61 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1-14-86 19 | | 7d. HOUR 7:4a M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Construction | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 623 N. Mount Ford AVE 21205 | | | |
| 13a. STATE MD | 13b. COUNTY | | 13c. CITY OR TOWN BALTO. | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST IKE LLOYD | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOTTIE OSBORNE | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) ? | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS HAZEL Wood 1418 E. Federal St | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Margareta A. Korell | | | TITLE (SPECIFY) M.D. Assistant | | | DATE SIGNED 1-14-86 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | | ADDRESS 111 Penn Street | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL | | | 23b. DATE 1/17/86 | | 23c. NAME OF CEMETERY OR CREMATORY RAFTON Creek | | | 23d. LOCATION CITY OR TOWN COUNTY STATE SUMTER S.C. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Locks FUNERAL Home 1304th Central Ave | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 17 1986 | | 25b. REGISTRAR'S SIGNATURE John Davidson | | | | |

DHMH - 17
(VR A15 ME (5))

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UNION
MAY 1962



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|---|--|--|---|---|----------------------------------|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LEOLA GARY | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 8, 1986 | | 2b. HOUR P M 6:00 P | | | | | | |
| 3. SEX F | | 4. RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR 7 4 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS 88 | | 7. IF UNDER 1 YEAR MONTHS DAYS 88 | | 8. IF UNDER 24 HRS. HOURS MIN. 88 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MARYLAND | | | | 13b. COUNTY BALTIMORE | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE 1632 N. GAY ST. 21213 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST CICERO HARRIS | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JANE RHEEMS | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-07-5343 | | 17. INFORMANT ADDRESS IDA ADAMS 1632 N. GAY ST. 21213 | | | | | |

| | | | |
|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | |

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/26/85 , 19____, to 1/8/86 , 19____, that (I) (we) last saw the deceased alive on 1/8/86 , 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (yes) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Patricia L. Garner | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/8/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) PATRICIA L. GARVER | | | | 22e. ADDRESS Johns Hopkins Hospital, Balt. | | | |

| | | | | | | | |
|--|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL BURIAL | | 23b. DATE 1-13-86 | | 23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL | | 23d. LOCATION CITY OR TOWN COUNTY STATE ANNE ARBOR UNDELMARYLAND | |
| 24. FUNERAL DIRECTOR NAME WM.C. MARCH F/H INC. 1101 E. NORTH AVE. | | | | 25. DATE RECEIVED BY REGISTRAR JAN 10 | | | |
| 26. REGISTRAR'S SIGNATURE | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please detach and forward to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

2 50 PPL
1 APRIL YEAR
1 APRIL YEAR



20% COTTON FIBER

CHIEF DEPT DOWD

038003

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01058

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | | | | | |
|---|--|--------|-------------------|---|--|------------------------------------|--|--|----------------|---|--|--|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE KNOWN OF DEATH | | | MONTH DAY YEAR | | | 2b. HOUR | | | |
| Joseph | | | Gates | | | 1/ 24/ 19 86 | | | | | | M | | | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| Male | | White | | 5 16 27 | | 58 YRS. | | MONTHS DAYS | | HOURS MIN. | | 1/ 24/ 19 86 | | 6:20 P M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| | | | | U.S. | | | | | | | | Baltimore City, MD. | | | |
| 11. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | | | 232 S. Broadway | | | | | | | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| Md. | | | | | | Balto. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 232 S. Broadway | | 21231 | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | ADDRESS | | | |
| Yes | | | | 165-22-0786 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | |
| (b) <u></u> | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (c) <u></u> | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | |
| <u>Chronic Alcoholism</u> | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | | |
| | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on | | | | | | | | | | | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | |
| death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | |
| TITLE (SPECIFY) | | | | | | | | | | | | DATE SIGNED | | | |
| M.D. Assistant MEDICAL EXAMINER | | | | | | | | | | | | 1/25/86 | | | |
| ACTUAL SIGNATURE | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | | | | | | | | | | | | |
| Gregory R. Kauffman, M.D. | | | | | | | | | | | | ADDRESS 111 Penn St. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Removal | | | | 2/4/86 | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Anatomy Board | | | | | | Balto., Md. | | | | | | FEB 06 1986 | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

60340

20% COTTON 60/2

FEB 19 1966

017016

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | | |
|---|--|--|--|--|---------------------------|--|
| 1 DECEASED NAME (TYPE OR PRINT) ALEXANDER A. GEHL | | | 2a DATE OF DEATH MONTH DAY YEAR 1 - 11 - 86 | | 2b HOUR 3:10 PM | |
| 3 SEX MALE | | 4 RACE white | | 5 DATE OF BIRTH MONTH DAY YEAR 10 - 27 - 05 | | |
| 6 AGE (IN YEARS LAST BIRTHDAY) 80 | | 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MINNESOTA | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | |
| 10 CITY OR TOWN OF DEATH BALTO. MD | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECURITY | | |
| 12b KIND OF BUSINESS OR INDUSTRY AIRCRAFT Co. | | 13a STATE MD. | | 13b COUNTY BALTO. | | |
| 13c CITY OR TOWN BALTO. | | 13d INSIDE CITY LIMITS? NO | | 13e STREET ADDRESS / ZIP CODE 2515 WENTWORTH RD. 21234 | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST WILLIAM GEHL | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) YES | | 16b SOCIAL SECURITY NO. 217-12-3797 | | 17 INFORMANT ADDRESS Mr. Rand E. Held - 2515 Wentworth Rd. 21234 | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC CANCER TO LIVER DUE TO, OR AS A CONSEQUENCE OF (c) BLADDER CANCER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a I certify that (this hospital) attended the deceased from January 9, 1986 to January 11, 1986 , that (we) last saw the deceased alive on January 11, 1986 , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death. | | | | | | |
| 22b SIGNATURE M. L. Bijpuria M.D. | | | | 22c DATE SIGNED 1-11-86 | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) M.L. BIJPURIA M.D. | | | | 22e ADDRESS Church Hospital Corp. 100 N. Broadway Balto. Md | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b DATE 1-15-85 | | 23c NAME OF CEMETERY OR CREMATORY MORELAND MEM. | | |
| 23d LOCATION CITY OR TOWN COUNTY STATE BALTO. MD. | | 24 FUNERAL DIRECTOR NAME ADDRESS Miller 7527 Hanford Rd. | | | | |
| 25a DATE REC'D. BY REGISTRAR JAN 14 1986 | | 25b REGISTRAR'S SIGNATURE [Signature] | | | | |

MEDICAL CERTIFICATION

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21-02-01

41-11-01

11-11-01

11-11-01

11-11-01

11-11-01



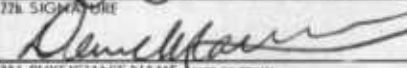

014057

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01060

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) LATISHA FATIMA GHANI | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 7 86 | | | 2b. HOUR 10:01 PM | | | |
| 3. SEX FEMALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 8 8 84 | | 6. AGE (IN YEARS LAST BIRTHDAY) 1 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL OF MARYLAND | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NA | | 12b. KIND OF BUSINESS OR INDUSTRY NA | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 4952 DENMORE AVENUE 21215 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ABDUR-RAHIM A. GHANI | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MONICA BROWN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. NA | | 17. INFORMANT MONICA GHANI | | ADDRESS 4952 DENMORE AVE 21215 | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) RESPIRATORY ARREST Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) TRACHEOSTOMY TUBE FALLING OUT | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 10 12 | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) BRONCHIO PULMONARY DISPLASIA | | | | | | | | | |
| 19a. DATE OF OPERATION NA | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NA | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. NA 19 85 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) NA | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) NA | | 21f. LOCATION STREET NA | | CITY OR TOWN NA | | COUNTY NA | |
| 22a. I certify that (I) the deceased died on <u>July</u> , 19 <u>85</u> , to <u>December</u> , 19 <u>85</u> , that (II) (we) last saw the deceased alive on <u>12/31</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE  | | | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/7/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DERRICK K. MATTHEWS | | | | 22e. ADDRESS PARK WEST MEDICAL CENTER 3319 W. BELVEDERE AVE BAL, 21215 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 1/11/86 | | 23c. NAME OF CEMETERY OR CREMATORY Westview Mem. Pk. | | 23d. LOCATION CITY OR TOWN Balto. Co. Md. | | COUNTY MD. | |
| 24. FUNERAL DIRECTOR NAME MARSHALL W. JONES JR | | | | ADDRESS 4101 Edmondson Ave | | 25a. DATE REC'D. BY REGISTRAR JAN 10 1986 | | 25b. REGISTRAR'S SIGNATURE  | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please enclose completed Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

010083

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Gretta J. Gibbons | | | 2a. DATE OF DEATH MONTH DAY YEAR 1/6/86 | | | 2b. HOUR 115/A M | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 10 19 98 | | 6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto., City MD. | | | |
| 10. CITY OR TOWN OF DEATH Balto. City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garden Village Nursing Ctr. Housewife | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | | | 13b. COUNTY N/A | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Wright | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara Fuler | | | 13e. STREET ADDRESS 5220 York Rd. 21212 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) -NO | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A | | 17. INFORMANT Garden Village | | ADDRESS Balto., Md. 21206 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Lobar Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| Chronic Hepatitis: Alcoholic Disease | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 9/8/19 28 to 1/6/19 86 , that (I) (we) lost saw the deceased alive on 12/29/19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Albert B. Bradley | | | DEGREE MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/17/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Albert B. Bradley | | | 22e. ADDRESS 4900 Belair Rd. Balto., Md. 21206 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1-9-86 | | 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md. | | |
| 24. FUNERAL DIRECTOR NAME John M. Weber & Sons Inc. | | | ADDRESS 401 S. Chester St. | | | 25a. DATE REC'D. BY REGISTRAR JAN 8 1986 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please return page 3 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1997年12月25日

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | REG. NO. | | | |
|---|--|--|--|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) GONZLEE | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 01 22 86 | | | |
| 3. SEX MALE | | | | | 7b. HOUR 2 30 M | | | |
| 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 08 04 21 | | 6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSP OF BALT | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER | | 12b. KIND OF BUSINESS OR INDUSTRY PRODUCE | | |
| 13a. STATE MD | | 13b. COUNTY BALT | | 13c. CITY OR TOWN BALT | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST LUKE | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMY - ALLEN | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> (IF YES, GIVE WAR OR DATES) NO. | | 16b. SOCIAL SECURITY NO. 24722-4763 | | |
| 16c. ADDRESS 5250 ST. CHARLES AVEN. 21215 | | 16d. ADDRESS 5250 ST. CHARLES AVEN. 21215 | | 16e. ADDRESS 5250 ST. CHARLES AVEN. 21215 | | 16f. ADDRESS 5250 ST. CHARLES AVEN. 21215 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYOCARDIAL MI DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). ISCHEMIC CARDIOMYOPATHY, ASCVD, P.V.D. | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | 21d. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 21e. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21g. LOCATION STREET CITY OR TOWN COUNTY STATE | | 21h. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/22 1986 to 1/22 1986 , that (I) (we) last saw the deceased alive on 1/22 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE VORPERIAN, V. 9015 | | DEGREE M.D. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/22/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) VORPERIAN, V. 9015 | | 22e. ADDRESS S. H. B. | | 22f. ADDRESS S. H. B. | | 22g. ADDRESS S. H. B. | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 1/28/1986 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | |
| 24. FUNERAL HOME OR RECEPTION OFFICE NAME ADDRESS MUTTER & SONS FUNERAL HOME, INC. 2501 GWYNNS FALLS PKWY. BALTIMORE, MD. 21216 | | | | 25a. DATE REC'D BY REGISTRAR JAN 24 1986 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | |

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Maryland

2501 GAYTHES FALLS PKWY. BALTIMORE, MD. 21216
WILLIAMS & SON'S FUNERAL HOME, INC.
1355 N. 10TH ST. BALTIMORE, MD. 21206

010127

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|--|--|--|--|--|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) LORRAINE Mae GIBSON | | | 2a DATE OF DEATH MONTH DAY YEAR 01 03 86 | | | 2b HOUR 3³⁰ PM | | | |
| 3 SEX Female | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR 4 18 1924 | | 6 AGE (IN YEARS LAST BIRTHDAY) 61 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10 CITY OR TOWN OF DEATH Baltimore | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk | | 12b KIND OF BUSINESS OR INDUSTRY Food Service | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland | | 13b COUNTY Baltimore | | 13c CITY OR TOWN Baltimore | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS / ZIP CODE 6201 Fortview Way 21224 | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Anthony W. Newell | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hazel Hager | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | 16b SOCIAL SECURITY NO. 236/22/8075 | | 17 INFORMANT ADDRESS Linda Peterson 8543 Summit Rd. 21122 | | | | |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **STROKE**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost

(b) **Artery Disease**
Carotid Endarterectomy

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
11/20/85

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 11/17/85 19____, to 11/3/86 19____, that (I) (we) last saw the deceased alive on 11/3/86 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE Dena S. Supler | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c DATE SIGNED 1/3/86 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) SIMPLERAD | | | | 22e ADDRESS MERCY HOSPITAL | | | |

| | | | | | | | |
|--|--|-----------------------------|--|---|--|---|--|
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b DATE 1/6/1986 | | 23c NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery | | 23d LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, Maryland | |
| 24 FUNERAL DIRECTOR NAME ADDRESS Walter Brooks Bradley Inc. Balto., Md. 21222 | | | | 25a DATE REC'D. BY REGISTRAR JAN 8 1986 | | 25b REGISTRAR'S SIGNATURE Linda Peterson | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and immediately filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate to the State Department of Health and Mental Hygiene prior to burial, cremation, or other disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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2902 COLLECTOR LITEN

CHIEF MAN



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | |
|--|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) JOHN/GILBERT | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 28, 1986 | | 2b. HOUR 8:20 A |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 7 31 14 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic | 12b. KIND OF BUSINESS OR INDUSTRY Dairy Products |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Russell Gilbert | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hallie Barker | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 719-10-6660 | | 17. INFORMANT NAME ADDRESS Mrs. Thelma E. Gilbert, 2014 E. Pratt Street Baltimore, Md. 21231 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BLADDER CANCER WITH METASTASIS DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that (I) (this hospital) attended the deceased from JANUARY 5, 19 86 to JANUARY 28, 19 86 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on JANUARY 22, 19 86 , and that in my <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death) | | | | |
| 22b. SIGNATURE <i>Chi Shiang Chen</i> | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1-28-86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHI SHIANG CHEN MD | | 22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTO., MD. 21231 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 1-31-86 | 23c. NAME OF CEMETERY OR CREMATORY Holly Hill Mem. Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Baltimore Md. |
| 24. FUNERAL DIRECTOR NAME ADDRESS Ann S. Matthews, Matthews Funeral Home 3021 Eastern Ave., Baltimore, Md. | | 25a. DATE REC'D. BY REGISTRAR JAN 30 1986 | | 25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Henderson</i> |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filing by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate should be filed at once.



UNION MILITARY

ARMY NOTICE

JAN 10 1961

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) BENJAMIN D. GINSBERG | | | 2a. DATE OF DEATH MONTH DAY YEAR 01 19 86 | | | 2b. HOUR 3:07 P.M. | | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH FEB. 22, 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PHARMACIST | | 12b. KIND OF BUSINESS OR INDUSTRY DRUGS | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTO. | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 3909 SEVEN MILE LA. 21208 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ABRAHAM GINSBERG | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FANNIE UNKNOWN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-16-0739 | | 17. INFORMANT DR. RONALD GINSBERG 6533 GARDENWICK RD. BALTO., MD 21209 | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF

(b)

massive hemoptysis

DUE TO, OR AS A CONSEQUENCE OF

(c)

probable ruptured aneurysm.

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) this hospital attended the deceased from 1-19, 19 86, to 1-19, 19 86, that (1) (we) last saw the deceased alive on 1-19, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Michael McIvor | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1-19-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL MCIVOR MD | | 22e. ADDRESS SINAI HOSPITAL OF BALTIMORE | | | | | |

| | | | | | | | |
|---|--|----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE JAN. 21, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY MIKRO KODESH-BETH ISRAEL | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | 25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | | |

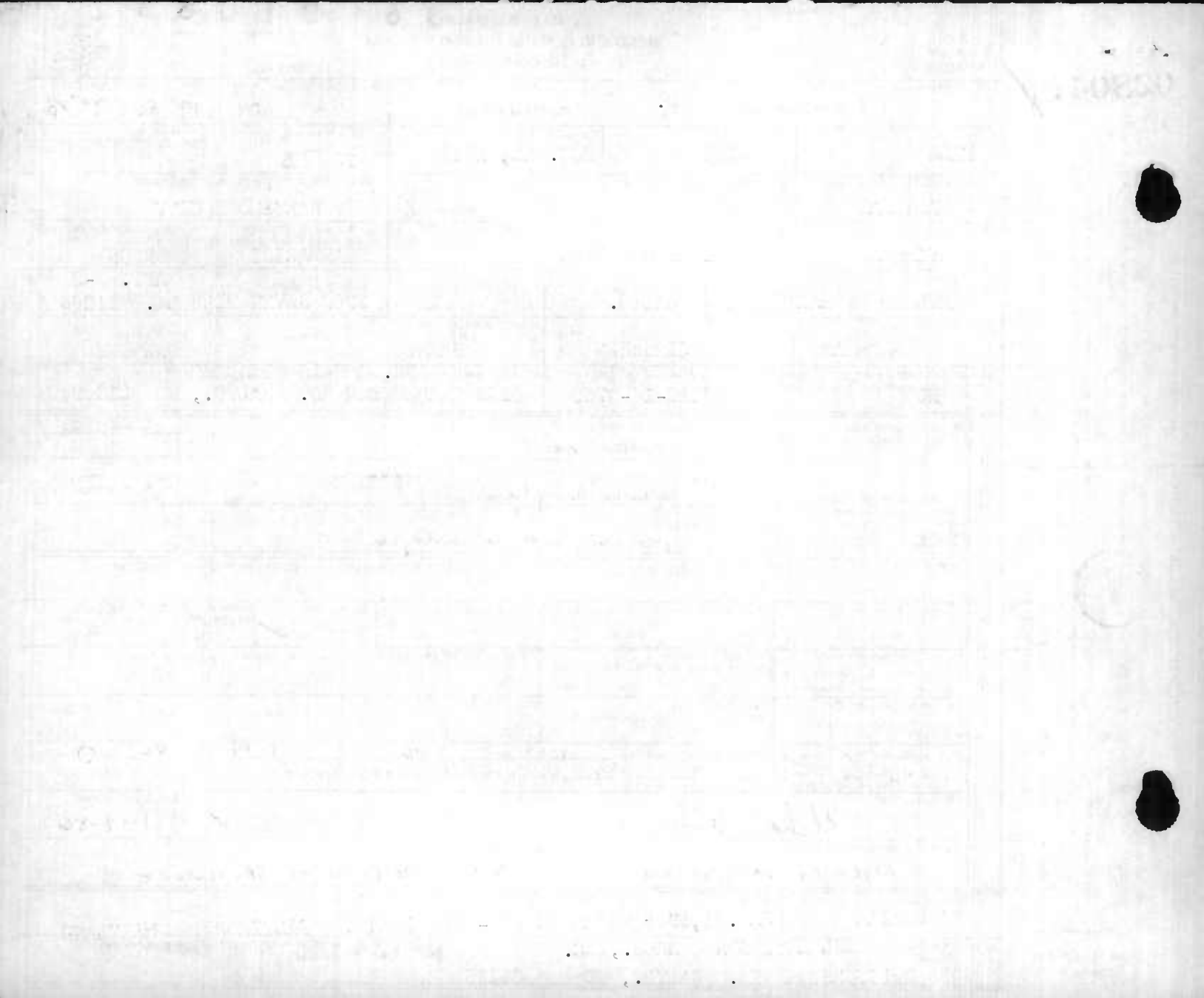
BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The death certificate must be completed and filed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

028041



010061

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|---|--|---|---|--|---|--|---|-----------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) Aurora | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 6 86 | | | 2b. HOUR 2:40 am | | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 9, 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 4768 Shamrock Ave. 21206 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Salvatore Pasqua | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Joan | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 217-18-5099 | | 17. INFORMANT Mrs. Rosalie M. Harvey | | ADDRESS 9615 Trepid Rd. | | 21236 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory S.I. M.I. DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/6 , 19 86 , to 1/6 , 19 86 , that (I) (we) last saw the deceased alive on 1/6 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE L.S. Farnick | | | | | | DEGREE MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/6/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) LMAD S. FARNICK | | | | | | 22e. ADDRESS Union Memorial Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1-9-86 | | 23c. NAME OF CEMETERY OR CREMATORY St. Joseph-Fullerton | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | | | |
| 24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. | | | | | | ADDRESS Baltimore, Md. | | 25a. DATE REC'D. BY REGISTRAR JAN 8 1986 | | 25b. REGISTRAR'S SIGNATURE | |

MEDICAL CERTIFICATION

29

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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• May 1967 •

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Journal of Management Education

2011

Figure 1

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|---|--|-----------------------------------|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | MONTHS DAYS HOURS MIN. | |
| JACOB Raymond GNAGEY | | 1 16 86 | | 5A.M. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| Male | White | MONTH DAY YEAR | 61 YRS | IF UNDER 24 HRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Maryland | USA | | Baltimore City MD | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Baltimore | 1000 Arion Park Rd. Apt. 71 | | Merchand Seaman | | Dept. of Navy |
| 13a. STREET ADDRESS / ZIP CODE | | 13b. INSIDE CITY LIMITS? | | | |
| 1000 Arion Park Rd. Apt. 71 | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| Jacob Raymond Grangey, Sr. | | Beulah V. Bender | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| Yes WWII | | 220-16-5743 | | 1000 Arion Park Rd. Apt. 71; Baltimore, MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular arrest</u> (b) <u>Pulmonary infarction</u> (c) <u>Diabetes Mellitus</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes Mellitus</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1982</u> to <u>1985</u> , that (I/we) last saw the deceased alive on <u>OCT 19 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | |
| <u>Artemio Miranda</u> | | Jan. 16, 1986 | | Artemio Miranda, M.D. | |
| 22e. ADDRESS | | 22f. DATE REC'D. BY REGISTRAR | | 22g. REGISTRAR'S SIGNATURE | |
| 1010 St. Paul St. | | JAN 24 1986 | | <u>Artemio Miranda</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 1/19/86 | | Grantsville Cemetery | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE | | 23e. DATE REC'D. BY REGISTRAR | | 23f. REGISTRAR'S SIGNATURE | |
| Grantsville, Garrett, MD | | JAN 24 1986 | | <u>Artemio Miranda</u> | |
| 24. NEWMAN FUNERAL HOMES P.O. Box 267, Grantsville, Md. 21536 | | | | | |

MEDICAL CERTIFICATION

028603

NO. 2 COTTON LINTS

WATKINS



009108

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|---|--|---|--|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) George Edward Goetzinger Sr. | | | 2a. DATE OF DEATH MONTH DAY YEAR January 6, 1986 | | | 2b. HOUR A. M. | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 12 2 07 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 78 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical Center | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY General Mtrs. | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Harbor View | | |
| 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13e. STREET ADDRESS / ZIP CODE 621 South 46th. Street 21224 | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Bernard Goetzinger | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NOT OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- 216-03-0566 | | 17. INFORMANT ADDRESS Lelia L. Goetzinger 621 S. 46th. St. 21224 | | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe disturbance pulmonary</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Emphysema</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Arteriosclerotic Cardiovascular Disease</u> | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE <u>Patricia P. PATRIGIO</u> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Patricia P. PATRIGIO | | | | 22e. ADDRESS | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-9-86 | | 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Eastwood, Balto. Co., Md. | | |
| 24. FUNERAL DIRECTOR NAME Charles S. Zeiler & Son Inc. ADDRESS 6224 Eastern Ave. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 7 1986 | | | | |
| 25b. REGISTRAR'S SIGNATURE <u>John J. ...</u> | | | | | | | | |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please indicate on the papers, Pages 1 and 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Section 100-10000

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010135

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

01069

 1- FOR
 STATE
 REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|--|---|--|------------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <i>Cecilia Goldberg</i> | | | 2a. DATE OF DEATH MONTH <i>JAN</i> DAY <i>4</i> YEAR <i>86</i> | | 2b. HOUR <i>1050 A.M.</i> | | |
| 3 SEX <i>Female</i> | | 4. RACE <i>Caucasian</i> | | 5. DATE OF BIRTH MONTH <i>5</i> DAY <i>15</i> YEAR <i>1905</i> | | 6 AGE (IN YEARS LAST BIRTHDAY) <i>80</i> YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Russia</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH <i>BALTO CITY</i> MD. | |
| 10. CITY OR TOWN OF DEATH <i>BALTO</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>LEVINDALE AGED HOME</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOUSEWIFE</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i> | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MARYLAND</i> 13b. COUNTY <i>BALTO</i> 13c. CITY OR TOWN <i>RANDALLSTOWN</i> | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE <i>8808 ALLENSWOOD RD. 21133</i> | |
| 14. FATHER'S NAME FIRST <i>HTRSH</i> MIDDLE <i>GAMERMAN</i> LAST <i>UNKNOWN</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST <i>SARAH</i> MIDDLE <i>UNKNOWN</i> LAST <i>UNKNOWN</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) <i>NO</i> | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT ADDRESS <i>RANDALLSTOWN</i> <i>BERNARD KLEGER 8808 ALLENSWOOD RD. 21133</i> | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ASPIRATION PNEUMONIA</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>CVA</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 wk.</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>8-2</i> 19 <i>82</i> to <i>1-4</i> 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>1-4</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>[Signature]</i> DEGREE | | | | 22c. DATE SIGNED <i>1-4-86</i> | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>B. ZAWININ</i> | |
| 22e. ADDRESS <i>LEVINDALE CENTER MD 21215</i> | | | | 22f. PHYSICIAN'S NAME (TYPE OR PRINT) <i>B. ZAWININ</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i> | | 23b. DATE <i>1/5/86</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>SHAAREI TFILOH CEM</i> | | 23d. LOCATION CITY OR TOWN <i>BALTO</i> COUNTY <i>MARYLAND</i> STATE <i>MARYLAND</i> | |
| 24 FUNERAL DIRECTOR NAME <i>SOL LEVINSON & BROS., INC.</i> ADDRESS <i>6010 REISTERSTOWN RD. BALTO, MD 21215</i> | | | | 25a. DATE REC'D. BY REGISTRAR <i>JAN 8 1986</i> 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified at once. IMPORTANT.

30



BP

DHMH - 16 50M 4/83
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

020252

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

01070

| | | | | | | | | | |
|--|--|---|---|---|--|---|--|------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) <u>Samah Golbora</u> | | | 2a. DATE OF DEATH MONTH DAY YEAR <u>1/13/86</u> | | | 2b. HOUR <u>3 A</u> M | | | |
| 3. SEX <u>F</u> | | 4. RACE <u>W</u> | | 5. DATE OF BIRTH MONTH DAY YEAR <u>3 8 12</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>73</u> YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Balto.</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>BALT. CITY</u> MD. | | | |
| 10. CITY OR TOWN OF DEATH <u>BALT.</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>SINAI</u> | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u> | | |
| 13a. STATE <u>MD</u> | | 13b. COUNTY <u>BALTO</u> | | 13c. CITY OR TOWN <u>BALT.</u> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <u>MAX Malin</u> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Rebecca Soph</u> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <u>NO</u> | | | | | |
| 16b. SOCIAL SECURITY NO. <u>213-01-0849</u> | | 17. INFORMANT ADDRESS <u>Mrs. B. Hettelman 7 Schloss Ct. 21208</u> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>LUL Adenocarcinoma of lung</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Pancytopenia, CHF</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on <u>1/12/86</u> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death. | | | | | | | | 22c. DATE SIGNED <u>1/13/86</u> | |
| 22b. SIGNATURE <u>Mark A. Goldstein MD</u> | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MARK A. GOLDSTEIN</u> | | 22e. ADDRESS <u>SINAI HOSPITAL</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>1-14-86</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>OH EB SHALOM</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Reisterstown BALTO Md.</u> | | | |
| 24. FUNERAL DIRECTOR NAME <u>HEBREW MEMORIAL F.H. INC.</u> | | ADDRESS <u>1100 Reisterstown RD. BALTO. MD</u> | | 25a. DATE REC'D. BY REGISTRAR <u>JAN 16 1986</u> | | 25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Rendell</u> | | | |

MEDICAL CERTIFICATION

023087

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3, RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4
25MBP
DHMH - 17
(VR A15 ME (5))

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 01071 | |
|---|--------------|--|---|---|---|---|--|---|--|----------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) Robert Goldie | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1/ 10/19 86 | | 2b. HOUR 8:46 | | | |
| 3. SEX M | 4. RACE B | 5. DATE OF BIRTH MONTH DAY YEAR 10 31 05 | 6. AGE (IN YEARS) LAST BIRTHDAY 80 YRS. | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1/ 10/19 86 | | 7d. HOUR A M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Unkn | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1100 Pennsylvania Ave. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE MD | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1100 Pennsylvania Ave. k 21201 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Unkn | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unkn | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Unkn | | | 16b. SOCIAL SECURITY NO. 219-10-4389 | | 17. INFORMANT Dan Seamon | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 1/10/86 | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. | | | ADDRESS 111 Penn St. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1/21/86 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD | | | | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H, Inc. ADDRESS 1101 E. North Avenue | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 21 1986 | | 25b. REGISTRAR'S SIGNATURE | | | | |

[Faint, illegible text covering the page, likely bleed-through from the reverse side.]

024057

1- FOR
STATE
REGISTRARSTATE OF MARYLAND 8 6
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01072

REG. NO.

| | | | | | |
|--|--|--|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) ABBEY J GOLDMAN | | | 2a. DATE OF DEATH MONTH DAY YEAR 1. 19. 86 | | 2b. HOUR 308 PM |
| 3. SEX FEMALE | 4. RACE C 1 | 5. DATE OF BIRTH MONTH DAY YEAR 8 7 19 | | 6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY CITY HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |

| | | | | |
|---|--|--|---|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY BALTIMORE 13c. CITY OR TOWN BALTIMORE | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS, ZIP CODE 833 W. PRATT ST. 21201 |
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| | |
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| 14. FATHER'S NAME (FIRST MIDDLE LAST) WARREN MALCOLM | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) BEULAH MARIE BROWN |
|--|---|

| | | |
|--|--|---|
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 145-22-2177 | 17. INFORMANT ADDRESS ALBERTA MORGAN 2621 HAPER ST. |
|--|--|---|

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiopulmonary arrest | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

| | | | |
|--|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.

| | | | |
|--|---|--|------------------------------------|
| 22b. SIGNATURE MD | DEGREE | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED 1.19.86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) KHETZU | 22e. ADDRESS UNIV MD HOSPITAL | | |

| | | | |
|--|------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE 01-24-86 | 23c. NAME OF CEMETERY OR CREMATORY MT. ZION CEM. | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MARYLAND |
|--|------------------------------|--|--|

| | | |
|--|---|--|
| 24. FUNERAL DIRECTOR NAME BROWN THOMPSON F. H. | 25a. DATE REC'D. BY REGISTRAR JAN 22 1986 | 25b. REGISTRAR'S SIGNATURE Julia Trindon-Rodgers |
|--|---|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by a physician who attended the deceased or by a physician retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

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RECEIVED JAN 10 1964
U.S. AIR FORCE
HONOLULU, HAWAII

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN THE SPACE PROVIDED. PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR ANATOMICAL DONATION.

07/84
25M

DHMH - 17
(VR A15 ME (5))

| 1 - FOF - STATE REGISTRAR | | | | | | | | | | 3 - DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 5 - 107-9 | | | | | | | | | |
|--|--|---------------|--|---|--|--|--|--|--|--|--|--|--|----------------------|--|--|--|--|--|----------------------|--|--|--|--|--|--|--|--|--|
| 1 - STATE REGISTRAR | | | | | | | | | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) RUTH L. GOODE | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 4 1986 | | | | | | | | | | 2b. HOUR M 11:06 P M | | | | | | | | | |
| 3. SEX female | | 4. RACE black | | 5. DATE OF BIRTH MONTH DAY YEAR 10 22 1918 | | 6. AGE (IN YEARS) LAST BIRTHDAY 67 YRS. | | IF UNDER 1 YR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | | 2c. DATE PRONOUNCED DEAD 1 4 1986 | | 2d. HOUR M 11:06 P M | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ga | | | | 7b. CITIZEN OF WHAT COUNTRY? U S A | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital (DOA) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | | | 12b. KIND OF BUSINESS OR INDUSTRY Laundry | | | | | | | | | | | | | | | | | |
| 13a. STATE Md | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN Baltimore | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS 2207 Linden Avenue 21217 | | | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frazier Goode | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST N/A | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 257-28-5534 | | | | 17. INFORMANT ADDRESS Betty Bell 4311 Penhurst Avenue | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 10. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE [Signature] | | | | | | | | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | | | | | | | | DATE SIGNED 1-5-86 | | | | | | | | | | | | | | | | | | | |
| ADDRESS 111 Penn St., Balto., MD 21201 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 1/8/86 | | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus MD | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS William C. March F/H West 4300 Wabash Avenue | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 7 1986 [Signature] | | | | | | | | | | | | | | | | | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01074

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) BERNICE D. Gordon | | | 2a. DATE OF DEATH MONTH DAY YEAR 1/25/86 | | | 2b. HOUR 9:00A | | | |
| 3. SEX FEMALE | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 3 21 17 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH City | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deaton Hospital-South | | | | 12a. USUAL OCCUPATION (TYPE OF WORK YOU DID OR DID NOT DO FOR A LIVING) RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MARYLAND | | | 13b. COUNTY BALTIMORE | | | 13c. STREET ADDRESS ZIP CODE 9311 Edmonston Rd. 2070 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST MOSE CROCKETT | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Willie MAE Coyle | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. 577487499 | | | 17. INFORMANT Chart | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary arrest, CVD DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cholesterol DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0 | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/25/86 to 1/30/86 , 19 86 , that (I) (we) lost saw the deceased alive on 1/25 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE H. Tomlin | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | | 23b. DATE 1/30/86 | | 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln | | 23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD MARYLAND | | |
| 24. FUNERAL DIRECTOR NAME Charles Diggis Assoc. | | | | | ADDRESS 4311 23rd AVE. | | 25a. DATE REC'D. BY REGISTRAR JAN 30 1986 | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1- FOR
STATE
REGISTRAR

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1- FOR
STATE
REGISTRAR

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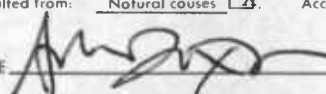
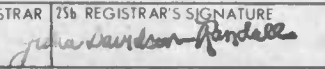
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

01075

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | | |
|---|-------------------------|--|--|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Lorenzo | | | 2a. DATE KNOWN OF DEATH MONTH 1 DAY 15 YEAR 1986 | | | 2b. HOUR M 12:42 P M | | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH 4 DAY 9 YEAR 09 | 6. AGE (IN YEARS) LAST BIRTHDAY 76 YRS. | IF UNDER 1 YR. MONTHS 0 DAYS 0 | IF UNDER 24 HRS. HOURS 0 MIN 0 | 2c. DATE PRONOUNCED DEAD MONTH 1 DAY 15 YEAR 1986 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 603 S. Ann Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Md. | | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Balto. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 603 S. Ann St. 21231 | |
| 14. FATHER'S NAME FIRST Md. MIDDLE Balto. LAST Balto. | | | | 15. MOTHER'S MAIDEN NAME FIRST Balto. MIDDLE Balto. LAST Balto. | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 532-12-7919 | | 17. INFORMANT ADDRESS | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE  | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 1/16/86 | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | ADDRESS 111 Penn St. Balto. MD. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b. DATE 1/21/86 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| 24. FUNERAL DIRECTOR NAME Anatomy Board ADDRESS Balto., Md. | | | | 25a. DATE REC'D. BY REGISTRAR FEB 05 1986 | | 25b. REGISTRAR'S SIGNATURE  | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL. IT MUST BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL. PAGE 5 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07110

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

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MADE IN U.S.A.



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017156

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|--|-------------------------------|--|--|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Joseph Grace</u> | | | 2a DATE OF DEATH MONTH DAY YEAR <u>1 13 86</u> | | 2b HOUR A M <u>4 43</u> | | | | |
| 3 SEX <u>Male</u> | | 4 RACE <u>Caucasian</u> | | 5 DATE OF BIRTH MONTH DAY YEAR <u>11 03 1918</u> | | 6 AGE (IN YEARS LAST BIRTHDAY) <u>67</u> YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Baltimore</u> | | 7b CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD. | | | |
| 10 CITY OR TOWN OF DEATH <u>Baltimore</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>St. Agnes Hospital</u> | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Furniture refinisher</u> | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <u>Maryland</u> | | | | 13b COUNTY <u>Baltimore</u> | | 13c CITY OR TOWN <u>Baltimore</u> | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST <u>William J. Grace</u> | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Katherine Eichelman</u> | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u> | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>214-34-2707</u> | | 17. INFORMANT ADDRESS <u>Christine Jowanowitch 1248 Stevens Ave. 21227</u> | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>45 minutes</u> | |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u> </u> P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (s) (this hospital) attended the deceased from <u>Jan 12</u> , 19 <u>86</u> , to <u>Jan 13</u> , 19 <u>86</u> , that (s) (we) lost saw the deceased alive on <u>Jan 13</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Robert E. Dupree, Jr. MD</u> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | | 22c. DATE SIGNED <u>1/13/86</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Robert E. Dupree, Jr. MD</u> | | | | | | 22e. ADDRESS <u>900 Caton Ave Baltimore MD</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>1/15/86</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore Baltimore Md.</u> | | | |
| 24 FUNERAL DIRECTOR ADDRESS <u>Amrose Funeral Home 1328 Sulphur Spring Rd</u> | | | | | | 25a. DATE REC'D. BY REGISTRAR <u>JAN 14 1986</u> | | 25b. REGISTRAR'S SIGNATURE <u>John Tundum-Randall</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 60 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.



100% COTTON

MADE IN U.S.A.

021103

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|---|--|---|--|---|---|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William Edward Grace | | | 2a. DATE OF DEATH MONTH DAY YEAR January 14, 1986 | | 2b. HOUR 5:35pM | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 08-21-1894 | | 6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore | | 7b. CITIZEN OF WHAT COUNTRY? U. S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Wesley Home, Inc. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Brakeman | | 12b. KIND OF BUSINESS OR INDUSTRY R.R. Railroad | | |
| 13a. STATE Md. | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2211 W. Rogers Ave. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Edward Grace | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Idabelle Pfiefer | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 705-05-6034 | | 17. INFORMANT George E. Grace ADDRESS 4813 S. Haven Dr. 21043 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable Acute Cerebrovascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular Disease</u> years DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic Cardiovascular Disease</u> Years | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>MAY 19 79</u> to <u>JUN 14 19 86</u> , that (I) (we) last saw the deceased alive on <u>12/30 19 85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>Robert E. Roby Jr.</u> | | | DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED <u>1/16/86</u> | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ROBERT E. ROBY, JR.</u> | | | 22e. ADDRESS <u>8817 Belair Road</u> | | | 22f. <u>21236</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/17/86 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Hubbard Funeral Home, Inc. 4107 Wilkens Ave. | | | 25a. DATE REC'D. BY REGISTRAR JAN 17 1986 | | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | |

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FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

01078

| | | | | | | | | | | |
|---|--|---|---|--|--------------------------------|---|---|---|---------|--|
| 1. DECEASED NAME (TYPE OR PRINT) GERALDINE M ^C QUADE GRAFTON | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 13, 1986 | | | 2b. HOUR 4 P.M. | | | | |
| 3 SEX FEMALE | | 4 RACE WHITE | | 5 DATE OF BIRTH MONTH DAY YEAR Nov. 28, 1897 | | 6 AGE (IN YEARS LAST BIRTHDAY) 88 YRS. | | 7a. IF UNDER 1 YEAR MONTHS DAYS 7b. IF UNDER 72 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | |
| 10 CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6201 LOCH Raven BLVD APT 505 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AT HOME | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE MARYLAND | | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST FRANK J. M ^C QUADE | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HENRIETTA MORRISON | | | 13e. STREET ADDRESS / ZIP CODE APT. 505 21239 6201 LOCH Raven BLVD. | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 21348 6221 | | 17 INFORMANT FAMILY RECORDS | | | | ADDRESS | |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BYIMMEDIATE CAUSE (a) Cardiopulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Atherosclerotic Cardiovascular Disease

DUE TO, OR AS A CONSEQUENCE OF

(c) Compulsive Heart FailureAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION N/A | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 13</u> , 19 <u>86</u> , to <u>Jan 13</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Jan 13</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>CHENG-CHUNG LIN</u> | | | | DEGREE | | 22c. DATE SIGNED JAN. 13, 1986 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHENG-CHUNG LIN | | | | 22e. ADDRESS 6801 Belair Rd Baltimore MD 21206 | | | |

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE Jan. 14, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | |
| 24. FUNERAL DIRECTOR NAME ADDRESS EVANS CHAPEL OF MEMORIES HARFORD RD. 8800 | | | | 25a. DATE REC'D. BY REGISTRAR JAN. 16 1986 | | 25b. REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED

15-9030

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[Faint, mostly illegible text covering the majority of the page, possibly bleed-through from the reverse side.]

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 01079

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Florence Mae Graves | | | 2a. DATE OF DEATH MONTH DAY YEAR 1-11-86 | | | 2b. HOUR 1:00 AM | | | |
| 3. SEX female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 7-20-08 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 | | 6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore MD | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEKEEPER | | 12b. KIND OF BUSINESS OR INDUSTRY SINAI HOSPITAL | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 5101 Levindale RD Baltimore, Maryland 21215 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Unknown | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No. | | | | 16b. SOCIAL SECURITY NO. 213-26-0242 | | 17. INFORMANT Mrs. Carleene Platter Baltimore, Maryland 2125 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dehydration - Sepsis DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: ischemic Stroke in 1977 | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-9 , 19 86 , to 1-11 , 19 86 , that (I) (we) lost saw the deceased alive on 1-10 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Daniel C. Hagan | | | | | | DEGREE MD. | | 22c. DATE SIGNED 1-11-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Daniel C. Hagan D.O. | | | | | | 22e. ADDRESS Sinai Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1/14/1986 | | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | |
| 24. FUNERAL DIRECTOR NAME NOTER & Sons Funeral Home, Inc. ADDRESS 2501 Gwynns Falls Pkwy. Baltimore, Md. 21216 | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 13 1986 | | 25b. REGISTRAR'S SIGNATURE Jana Davidson-Ponder | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

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5101 LEVENDALE RD
21215 F 07/20/86 M I
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | |
|--|---------|------------------------------|-------------------|--|------|--------------------------------------|------|---|--|---------------------|--|---------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE KNOWN OF DEATH | | | | 2b. HOUR | | | | | |
| VETOL S. GRAY | | | | MONTH DAY YEAR | | | | 1 28 19 86 | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | | | |
| Male | White | MONTH DAY YEAR | 52 YRS. | MONTHS | DAYS | HOURS | MIN. | 1 28 19 86 | | 3:05 P.M. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Md. | | U. S. A. | | | | Baltimore City MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | | | Bon Secours Hospital | | | | Helper | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | 13f. BALTO., MD. | |
| Md. | | | | | | Balto. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 122 S. Fulton Ave. | | #21223 | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| John Gray | | | | Mary Bruce | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | 17c. ADDRESS | |
| Yes | | | | 216-30-9380 | | | | Mrs. Stella J. Gross | | | | 15753 Dover Rd. - Upperco, Md. #21155 | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b) _____
DUE TO, OR AS A CONSEQUENCE OF

(c) _____

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | | | |
|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | |
| | | | | CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | |
| | | M.D. Assistant MEDICAL EXAMINER | | 1-29-86 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | |
| Ann M. Dixon, M.D. | | 111 Penn St., Balto., MD | | 21201 | |

| | | | | | | | |
|---|--|---------------|--|------------------------------------|--|----------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Burial | | Jan. 31, 1986 | | Garrison Forest Vets. Cen. | | Owings Mills, Md. | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| G. Truman Schwab | | | | FEB 03 1986 | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM TM 33, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/B4
25M

BP
DHMH - 17
(VR A15 ME (5))

00000

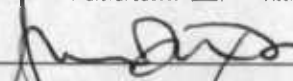
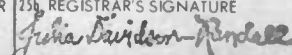


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010038

DIVISION OF VITAL RECORDS, 201 W. PRISTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. FIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. ALSO, FILL IN FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRISTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|-------------------------|--|---|---|--------------------------------|---|--|--|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) DANIEL R. GREEN JR. | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 4 19 86 | | 2b. HOUR AM | | | |
| 3. SEX MALE | 4. RACE BLACK | 5. DATE OF BIRTH MONTH DAY YEAR 05 05 1956 | 6. AGE (IN YEARS) LAST BIRTHDAY YRS. 29 | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 4 19 86 | | 2d. HOUR 2:30 AM | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5425 Reisterstown Rd. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disc Jockey | | 12b. KIND OF BUSINESS OR INDUSTRY Disco | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2509 W. Coldspring Lane Baltimore, Maryland 21215 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Daniel R. Green, Sr. | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Paula Matthews | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 74 - 75 | | 17. INFORMANT Mr. DANIEL R. GREEN SR. Baltimore, MD. | | 17a. ADDRESS 2509 W. Coldspring Lane 21215 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shotgun wound of thorax DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:23xx 1-4- 1986 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Subject shot. | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) building | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 5425 Reisterstown Rd., Balto. City MD | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 1-4-86 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | | ADDRESS 111 Penn St., Balto., MD 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/09/1986 | | 23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Veteran | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR'S NAME Nutter & Sons Funeral Home, Inc. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 8 1986 | | 25b. REGISTRAR'S SIGNATURE  | | | | | |
| 2501 Gwynns Falls Pkwy. Baltimore, Md. 21216 | | | | | | | | | | | |

07/B4
25MBP
DHMH - 17
(VR A15 ME (5))

021042

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST Melvin | | MIDDLE D. | | LAST Green | | 2a. DATE KNOWN OF DEATH XX MONTH DAY YEAR 1-20 19 86 | | 2b. HOUR M 5:50 a.m. | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 4 10 1923 | | 6. AGE (IN YEARS) LAST BIRTHDAY 62 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1-20 19 86 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Crane Operator | | 12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel | | | |
| 13a. STATE Maryland | | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Dundalk | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 4070 St. Augustine Lane 21222 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Leonard Green | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Peggie Belcher | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | | | 16b. SOCIAL SECURITY NO. WW II 234-24-8318 | | 17. INFORMANT ADDRESS Virginia Green Same as 13e | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Dennis F. Smyth M.D.</i> | | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 1-20-86 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. | | | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 1/23/1986 | | 23c. NAME OF CEMETERY OR CREMATORY Holly Hill | | 23d. LOCATION CITY OR TOWN COUNTY STATE White Marsh Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 22 1986 | | 25b. REGISTRAR'S SIGNATURE <i>J. E. Kiden</i> | | | |
| 7922 Wise Avenue Dundalk, Maryland 21222 | | | | | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE NO. OF THIS CERTIFICATE TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10-1. PAGE 5, FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 27 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

10

017127

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01083

1 FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|--|--|--|---|--|------------------------------|--|
| 1 DECEASED NAME (TYPE OR PRINT) Sylvia K. Green | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 10 86 | | 2b. HOUR 1:30 P.M. | |
| 3 SEX Female | | 4 RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 2 22 26 | | |
| 6 AGE (IN YEARS LAST BIRTHDAY) 59 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | | |
| 10 CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ. of Maryland Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled | | |
| 12b. KIND OF BUSINESS OR INDUSTRY Spring Grove Inst. | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Georgetown | | 13c. CITY OR TOWN Baltimore | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST George Keith | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sadie Brunson | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 216-24-2907 | | 17 INFORMANT ADDRESS Ellen Presco 1248 N. Augusta Ave | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Non-Hodgkin's Lymphoma DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Neurologic Dysfunction secondary to Radiation Therapy, Gastric Hypomotility | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec 19 1985 to January 10 1986 that (I) (we) lost saw the deceased alive on January 10 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | |
| 22a. SIGNATURE Russell P. DeLuca | | DEGREE | | 22c. DATE SIGNED 11/10/86 | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) Russell P. DeLuca | | 22e. ADDRESS 22, South Greene Street | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (RECEIVED) Burial | | 23b. DATE 1/16/86 | | 23c. NAME OF CEMETERY OR CREMATORY Md. Nat. Mem. Pk. | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Laurel, Md. | | | | | | |
| 24 FUNERAL DIRECTOR NAME Wm C March F/H West | | | | 25a. DATE REC'D. BY REGISTRAR JAN 14 1986 | | |
| ADDRESS 4300 Wabash Avenue | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the deceased should be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01084

024107

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|---|--|---|---|
| 1 DECEASED NAME (TYPE OR PRINT) THEODORE I. GREENFIELD | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 14, 1986 | | 2b. HOUR 9:30A M. | |
| 3. SEX MALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 5, 1902 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 83 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ILLINOIS | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3623 SEVEN MILE LA., APT. 2H | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CHEMICAL ENGINEER | | 12b. KIND OF BUSINESS OR INDUSTRY PAINT CO. |
| 13a. STATE MARYLAND | | 13b. COUNTY | 13c. CITY OR TOWN BALTIMORE | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST HYMAN GREENFIELD | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA UNKNOWN | | 16. STREET ADDRESS / ZIP CODE 3623 SEVEN MILE LA. #21208 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO 345-09-8211 | | 17. INFORMANT ADDRESS MRS. CLAIRE J. GREENFIELD APT. 2H BALTO., MD 21208 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Art. Sclerotic Cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) 10 yrs | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION none | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7:00 P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/4 1986 to 1/14 1986 , that (I) (we) lost saw the deceased alive on 1/14 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22a. SIGNATURE Maurice J. Feldman | | DEGREE | | 22b. DATE SIGNED 1/14/86 | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT) MAURICE J. FELDMAN, JR. | | 22d. ADDRESS 6610 CROSS COUNTRY BLVD. BALTO., MD 21215 | | 22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 1-19-86 | | 23c. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE REISTERSTOWN BALTO. MD | | 24. FUNERAL DIRECTOR NAME ADDRESS SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | |
| 25a. DATE REC'D. BY REGISTRAR JAN 22 1986 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

18010

UNITED STATES

031010

NOV 19 1950



NOV 19 1950

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NOV 19 1950

020036

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Norma Greensfelder</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>1 13 86</i> | | | 2b. HOUR <i>8:00 PM</i> | |
| 3. SEX <i>F</i> | | 4. RACE <i>W</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>1 31 33</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>62</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>USA</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City MD.</i> | |
| 10. CITY OR TOWN OF DEATH <i>Balt City</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Sinai Hosp.</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Secretary</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Mergenthal School</i> | |
| 13a. STATE <i>MD</i> | | 13b. COUNTY <i>Balt City</i> | | 13c. CITY OR TOWN <i>Balt City</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Henry E. Herrman</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Elsie Balt, Hinker</i> | | 17. INFORMANT ADDRESS <i>William Greensfelder, 4618 Asbury Ave. 21206</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>219-18-3197</i> | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) *Cardiac arrest*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last(b) *CHF*

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1/13</i> , 19 <i>86</i> , to <i>1/13</i> , 19 <i>86</i> , that (I) (we) lost saw the deceased alive on <i>1/13</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>Robert J. Entel, MD</i> | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <i>1/13/86</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Robert J. Entel, MD</i> | | 22e. ADDRESS <i>Sinai Hospital</i> | | | | | |

| | | | | | | | |
|--|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL <i>Burial</i> | | 23b. DATE <i>1-17-86</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Immanuel Cemetery</i> | | 23d. LOCATION COUNTY <i>Balto., MD</i> | |
| 24. FUNERAL DIRECTOR <i>John C. Miller, Inc., 6415 Belair Rd. 21206</i> | | | | 25a. DATE REC'D. BY REGISTRAR <i>JAN 16 1986</i> | | 25b. REGISTRAR'S SIGNATURE <i>Davidson</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be retained by the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

05003E



WILLIAM

100% COTTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4, may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7-84
(VRA 15, 4)

STATE OF MARYLAND 8 6 0 1 0 8 0
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1. STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|--|--|---|---|---|------------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>ROBERT W. GREENWOOD</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>1/30/86</i> | | 2b. HOUR <i>2:40 P.M.</i> | | |
| 3. SEX <i>Male</i> | | 4. RACE <i>black</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>6 17 09</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <i>76</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>N.C.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore city</i> MD. | |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (If NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Lutheran Hospital</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Unemployed</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE <i>Md</i> | | 13b. COUNTY | | 13c. CITY OR TOWN <i>Baltimore</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>N/A</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>N/A</i> | | 13e. STREET ADDRESS / ZIP CODE <i>21223 1430 W. Hollins St Apt 4</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i> | | 16b. SOCIAL SECURITY NO. <i>238-16-4388</i> | | 17. INFORMANT ADDRESS <i>Lillie M. Demsey</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIO PULMONARY ARREST</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>Sebastian A. Queto</i> DEGREE | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <i>1/30/86</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>SEBASTIAN A. QUETO</i> | | | | 22e. ADDRESS <i>LUTHERAN HOSPITAL</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>2/4/86</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Eastview Cemetery</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Md</i> | |
| 24. FUNERAL DIRECTOR <i>William C. March F/H West 4300 Wabash Avenue</i> | | | | 25a. DATE REC'D. BY REGISTRAR <i>FEB 04 1986</i> | | 25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | |

BP

10/1/60



RECEIVED

036157

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01087

FOR
1 - STATE
REGISTRAR

Danny J. Griffin

REG. NO.

| | | | | | |
|---|--|---|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) DANNY J. GRIFFIN | | | 2a DATE OF DEATH MONTH DAY YEAR 1 29 86 | | 2b HOUR 0640 |
| 1 SEX male | 1 RACE CAUC | 5 DATE OF BIRTH MONTH DAY YEAR 2/23/44 | 6 AGE (IN YEARS LAST BIRTHDAY) 38 YRS | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (COUNTRY) MD | 7b CITIZEN OF WHAT COUNTRY? USA | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH BALT. CITY MD. | | |
| 10 CITY OR TOWN OF DEATH Primer | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5136 H | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic | 12b. KIND OF BUSINESS OR INDUSTRY Paper Company | | |
| 13a. STATE MD | | | 13b. CITY OR TOWN Baltimore | 13c. STREET ADDRESS 754 Old Riverside Rd 21225 | |
| 14 FATHER'S NAME FIRST MIDDLE LAST ROBERT C. GRIFFIN | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GEORGIA A McFARLAND | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) No | 16b. SOCIAL SECURITY NO. 012 481239 | 17 INFORMANT ADDRESS Gladys Fulwiler Same as 13c | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrhythmia DUE TO, OR AS A CONSEQUENCE OF (b) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (this hospital) attended the deceased from 1-22-86 to 1-29-86 , that (I) (we) last saw the deceased alive on 1-29-86 , and that in (my) (our) apian death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE D. Buck, MD | | DEGREE MD | | 22c. DATE SIGNED 1-29-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. Buck, M.D. | | 22e. ADDRESS So. Balt. General Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 2/1/86 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | |
| | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore A.A. Md | |
| 24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hwy Balto Md | | | | 25a. DATE REC'D. BY REGISTRAR FEB 03 1986 | |
| | | | | 25b. REGISTRAR'S SIGNATURE John Andrew Randall | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director. Page 2 should be retained by the funeral director. Page 3 should be retained by the funeral director. Page 4 should be retained by the funeral director. Page 5 should be retained by the funeral director. Page 6 should be retained by the funeral director. Page 7 should be retained by the funeral director. Page 8 should be retained by the funeral director. Page 9 should be retained by the funeral director. Page 10 should be retained by the funeral director. Page 11 should be retained by the funeral director. Page 12 should be retained by the funeral director. Page 13 should be retained by the funeral director. Page 14 should be retained by the funeral director. Page 15 should be retained by the funeral director. Page 16 should be retained by the funeral director. Page 17 should be retained by the funeral director. Page 18 should be retained by the funeral director. Page 19 should be retained by the funeral director. Page 20 should be retained by the funeral director. Page 21 should be retained by the funeral director. Page 22 should be retained by the funeral director. Page 23 should be retained by the funeral director. Page 24 should be retained by the funeral director. Page 25 should be retained by the funeral director. Page 26 should be retained by the funeral director. Page 27 should be retained by the funeral director. Page 28 should be retained by the funeral director. Page 29 should be retained by the funeral director. Page 30 should be retained by the funeral director. Page 31 should be retained by the funeral director. Page 32 should be retained by the funeral director. Page 33 should be retained by the funeral director. 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Page 53 should be retained by the funeral director. Page 54 should be retained by the funeral director. Page 55 should be retained by the funeral director. Page 56 should be retained by the funeral director. Page 57 should be retained by the funeral director. Page 58 should be retained by the funeral director. Page 59 should be retained by the funeral director. Page 60 should be retained by the funeral director. Page 61 should be retained by the funeral director. Page 62 should be retained by the funeral director. Page 63 should be retained by the funeral director. Page 64 should be retained by the funeral director. Page 65 should be retained by the funeral director. Page 66 should be retained by the funeral director. Page 67 should be retained by the funeral director. Page 68 should be retained by the funeral director. Page 69 should be retained by the funeral director. Page 70 should be retained by the funeral director. Page 71 should be retained by the funeral director. Page 72 should be retained by the funeral director. Page 73 should be retained by the funeral director. Page 74 should be retained by the funeral director. Page 75 should be retained by the funeral director. Page 76 should be retained by the funeral director. Page 77 should be retained by the funeral director. Page 78 should be retained by the funeral director. Page 79 should be retained by the funeral director. Page 80 should be retained by the funeral director. Page 81 should be retained by the funeral director. Page 82 should be retained by the funeral director. Page 83 should be retained by the funeral director. Page 84 should be retained by the funeral director. Page 85 should be retained by the funeral director. Page 86 should be retained by the funeral director. Page 87 should be retained by the funeral director. Page 88 should be retained by the funeral director. Page 89 should be retained by the funeral director. Page 90 should be retained by the funeral director. Page 91 should be retained by the funeral director. Page 92 should be retained by the funeral director. Page 93 should be retained by the funeral director. Page 94 should be retained by the funeral director. Page 95 should be retained by the funeral director. Page 96 should be retained by the funeral director. Page 97 should be retained by the funeral director. Page 98 should be retained by the funeral director. Page 99 should be retained by the funeral director. Page 100 should be retained by the funeral director.

BP

7-18-50



REPORT OFFICE

TO: [illegible] FROM: [illegible]

RECEIVED

RECEIVED

DATE: [illegible] TIME: [illegible] BY: [illegible]

020042

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM 100. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|---|---------|--|----------------------------|---|---------------------|---|------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR | | |
| Edith Griffin | | | XX 1-5 19 86 | | | M | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR. | 8. IF UNDER 24 HRS. | 9. DATE PRONOUNCED DEAD | 2d. HOUR | |
| female | black | 10 9 1920 | 65 YRS | | | 1-5 19 86 | 11:08 a. M | |
| 10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 11. CITIZEN OF WHAT COUNTRY? | | 12. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 13. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Md | | U S A | | | | Baltimore City, MD | | |
| 14. CITY OR TOWN OF DEATH | | 15. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 16. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 17. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | | 2517 Liberty Heights Avenue | | Housewife | | | | |
| 18a. STATE | | 18b. CITY OR TOWN | | 18c. INSIDE CITY LIMITS? | | 18d. STREET ADDRESS | | |
| Md | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 2517 Liberty Heights Avenue 21215 | | |
| 19. FATHER'S NAME | | 20. MOTHER'S MAIDEN NAME | | | | | | |
| N/A | | N/A | | | | | | |
| 21a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 21b. SOCIAL SECURITY NO. | | 21c. INFORMANT ADDRESS | | | | |
| No | | 232-13-2444 | | Nellie G. Hannah 2517 Liberty Heights | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> . (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | |
| Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) Assistant | | | | MEDICAL EXAMINER | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | Dennis F. Smyth, M.D. | | | | DATE SIGNED 1-6-86 | | |
| ADDRESS | | 111 Penn St., Balto., Md. 21201 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| Burial | | 1/14/86 | | Mt Zion Cemetery | | Landsdown Md | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| William C. March F/H West 4300 Wabash Avenue | | | | JAN 14 1986 | | | | |

030015

REGIT NOTORI 2002

DMC

WINTER



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | | | | |
|---|--|---|--|---|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDWARD GRIFFIN | | | 2a. DATE OF DEATH MONTH DAY YEAR January 29, 1986 | | 2b. HOUR a 12:15 M | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR March 8, 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 73 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4317 Loch Raven Blvd. | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-employed | | 12b. KIND OF BUSINESS OR INDUSTRY Musician | |
| 13a. STATE MD | | | 13b. COUNTY | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Clarence E. Griffin | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Daisey Rauh | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II | | | 16b. SOCIAL SECURITY NO. 212 14 3609 | | 17. INFORMANT ADDRESS Mrs. Helen L. Griffin, Same | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ADVANCED METASTATIC CANCER DUE TO, OR AS A CONSEQUENCE OF (c) PROSTATE CANCER APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs ~10 yrs | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: NA | | | | | | | | |
| 19a. DATE OF OPERATION 1-23-85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED METASTATIC CA PROSTATE | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-12-1985 to 1-27-1986 , that (I) (we) last saw the deceased alive on 12-12-1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE Dr. Raiber Engle, MD | | DEGREE | | 22c. DATE SIGNED 1-30-86 | | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | |
| 22e. ADDRESS Union Memorial Hospital, Balto., MD | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/31/86 | | 23c. NAME OF CEMETERY OR CREMATORY Garrison Fst. Vet. | | 23d. LOCATION CITY OR TOWN COUNTY Garrison Forest, MD | | |
| 24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212 | | | | 25a. DATE REC'D. BY REGISTRAR JAN 31 1986 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon copiers. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

01090

 1. FOR
 STATE
 REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Evelyn D. Griffin | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 11 86 | | | 2b. HOUR 9 a M | | | |
| 3. SEX F | | 4. RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR 8 27 15 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2510 SALEM STREET | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MARYLAND | | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ROLAND GRIFFIN | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ORA L. GRIFFIN | | | 13e. STREET ADDRESS / ZIP CODE 2510 SALEM STREET 21217 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-22-7728 | | 17. INFORMANT ADDRESS WILLIAM GRIFFIN 4008 SPRUCE DR. 21215 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asystolia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>myocardial infarction & heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Diabetes Mellitus</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 11</u> , 19 <u>86</u> , to <u>Jan 11</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>Jan 11</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Paul Ivan Lopez</u> | | | DEGREE MD MPH | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <u>Jan 11, 1986</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul Ivan Lopez MD | | | 22e. ADDRESS 2400 Liberty Road | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 1-16-86 | | 23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL | | 23d. LOCATION CITY OR TOWN COUNTY STATE ANNE ARDUEL MARYLAND | | |
| 24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H INC. 1101 E. NORTH AVENUE | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE <u>John Davidson-Pandey</u> | | |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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| #1, Film G612 2/4/86 kam | | | | | | | | | | STATE OF MARYLAND | | 01091 | | | |
| 1- FOR STATE REGISTRAR | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) (AKA) FIRST MIDDLE LAST Mary L. Griffin | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1-27-86 | | | | 2b. HOUR 11:20 | |
| 3 SEX Female | | | 4. RACE White | | | 5. DATE OF BIRTH MONTH DAY YEAR July 25 1901 | | | 6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | | |
| 10 CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 1000 S. Caton Ave. 21229 | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | | 12b. KIND OF BUSINESS OR INDUSTRY - | | | |
| 13a. STATE Md. | | | 13b. COUNTY Baltimore | | | 13c. CITY OR TOWN Baltimore | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 3901 E. Joppa Rd. 21236 | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John S. Bayne | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice D. Edwards | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | 16b. SOCIAL SECURITY NO. 214-03-9982 | | | 17 INFORMANT ADDRESS Robert Griffin, Sr. (husband) same address | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>GT Bleeding</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <u>CVA - Bilateral</u> | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u> | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0 | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, PARK, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1124186 1127186 | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/25/86</u> 19 to <u>11/27/86</u> 19, that (I) (we) last saw the deceased alive on <u>11/25/86</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) did not know the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>George A. Napol</u> DEGREE | | | | | | | | | | 22c. DATE SIGNED 11/27/86 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>GEORGE A. NAPOL</u> | | | | | | | | | | 22e. ADDRESS <u>3350 - Wilkens Dr - Bal</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1/29/86 | | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | | | | | | |
| 24 FUNERAL DIRECTOR NAME ADDRESS Schimmunek Funeral Home, Inc. 9705 Belair Rd., Balto. Md. 21236 | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 31 1986 | | 25b. REGISTRAR'S SIGNATURE <u>Charles Burden-Rogers</u> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, age 4 months or more after death, or within 48 hours after death, if the death occurred in a hospital or nursing home. The law requires that the death certificate be signed by the attending physician and completed by the funeral director, pag 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

207 COLLEGE LANE

NEW YORK



NEW YORK

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) LEO | | | FIRST MIDDLE LAST LEO | | | 2a. DATE OF DEATH MONTH DAY YEAR 1/25/86 | | | 2b. HOUR 5:05a M | | |
| 3. SEX MALE | | | 4. RACE WHITE | | | 5. DATE OF BIRTH MONTH DAY YEAR 1 21 28 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Service Agent | | | 12b. KIND OF BUSINESS OR INDUSTRY Avis Rent a Car | | |
| 13a. STATE Maryland | | | 13b. COUNTY | | | 13c. CITY OR TOWN Baltimore | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Thomas Rickett | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gladys Griffith | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 216228976 | | |
| 17. INFORMANT ADDRESS Elizabeth I. Griffith 1829 McHenry St. | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BILATERAL BRONCHOPNEUMONIA AND PULMONARY HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC OBSTRUCTIVE PULMONARY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS 5-7 | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/18 19 86 , to 1/25 19 86 , that (I) (we) lost saw the deceased alive on 1/25 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Steven H. Pearlman | | | DEGREE M.D. | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 1/25/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEVEN H. PEARLMAN | | | 22e. ADDRESS ST. AGNES Hospital 900 S. CALDWAY AVE. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1/28/86 | | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | |
| 24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. | | | ADDRESS 4107 Wilkens Ave. | | | 25a. DATE REC'D. BY REGISTRAR JAN 27 1986 | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) LEE BABY MICHAEL GRIMES | | | 2a. DATE OF DEATH MONTH DAY YEAR 1/22/86 | | 2b. HOUR 3 P.M. |
| 3. SEX MALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR JAN. 14, 1986 | | 6. AGE (IN YEARS LAST BIRTHDAY) 8 YRS | IF UNDER 1 YEAR MONTHS DAYS 8 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE CITY | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY HARFORD 13c. CITY OR TOWN EDGEWOOD | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 303 WINTERBERRY DRIVE 21040 |
| 14. FATHER'S NAME FIRST MIDDLE LAST LAURENCE W. GRIMES, JR. | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BONNIE G. HOGAN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS FAMILY RECORDS | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a)

Cardiac ArrestAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**8 days**

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

Meningoencephalocoele, Encephalocoele

DUE TO, OR AS A CONSEQUENCE OF

(c)

TALISOMY 13

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

| | | | |
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| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/14/86 , 19 86 , to 1/22/86 , 19 86 , that (I) (we) last saw the deceased alive on 1/22/86 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE Charles Ashbrow MD | DEGREE MD | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED 1/22/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles Ashbrow MD | | 22e. ADDRESS UNION MEMORIAL Hospital Balto, MD | |

| | | | |
|---|-----------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE JAN. 25, 1986 | 23c. NAME OF CEMETERY OR CREMATORY DUBANSKY VAULT | 23d. LOCATION CITY OR TOWN COUNTY STATE TIMONIMUM BALTO. MARYLAND |
| 24. FUNERAL DIRECTOR NAME EVANS CHAPEL OF MEMORIALS HARFORD ROAD | | 25a. DATE REC'D. BY REGISTRAR JAN 24 1986 | 25b. REGISTRAR'S SIGNATURE W. W. Anderson |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a necropsy performed.

009073

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

01094

| | | | | | |
|---|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) PEARL B. GRISSON | | | 2a. DATE OF DEATH MONTH DAY YEAR 1/2/86 | | 2b. HOUR 8:30 PM |
| 3. SEX Female | 4. RACE BLACK | 5. DATE OF BIRTH MONTH DAY YEAR 04 24 38 | | 6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | 7b. CITIZEN OF WHAT COUNTRY? US | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore, MD. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired L.P.N. | 12b. KIND OF BUSINESS OR INDUSTRY Spring Grove State Hospital | |
| 13a. STATE MD. | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 1622 Edmondson Ave. 21223 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James Griffin | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALICE E. SPIVEY | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-32-9928 | 17. INFORMANT ADDRESS John Grisson 1622 Edmondson Ave | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Cardiac Arrest**

DUE TO, OR AS A CONSEQUENCE OF

(b) **HYPOTENSION 2° Hemodialysis**

DUE TO, OR AS A CONSEQUENCE OF

(c) **E.R.D.**APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

MEDICAL CERTIFICATION

| | | | |
|--|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/2 , 19 86 , to 1/2 , 19 86 , that (I) (we) lost saw the deceased alive on 1/2 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | |
| 22b. SIGNATURE Shirley J. Thomas | DEGREE MD | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED 1/2/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHIRLEY J. THOMAS | | 22e. ADDRESS Univ. of Maryland Hltht 22 S. Green St. Baltimore, MD 21201 | |

| | | | |
|---|----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 1/8/86 | 23c. NAME OF CEMETERY OR CREMATORY King Memorial Park | 23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown Md. |
| 24. FUNERAL DIRECTOR NAME ADDRESS William C. March F/H West 4300 Wabash Avenue | | 25. DATE SET D. BY REG. NO. 7 1986 26. REGISTRAR'S SIGNATURE [Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon copy and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.



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20X COLLECTION

022070

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01095

REG. NO.

| | | | | | | | | | | | | | | | |
|---|--|---|--|--|--------------------|--|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FRANCES E. GROSS | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 19 1986 | | 2b. HOUR 10am M | | | | | | | | | | |
| 3. SEX FEMALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR MARCH 23 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | 8. IF UNDER 24 HRS HOURS MIN. | | | | | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | | 9b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2886 KENTUCKY AVE. 21213 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER | | | 12b. KIND OF BUSINESS OR INDUSTRY - | | | | | | |
| 13a. STATE MD. | | | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 2886 KENTUCKY AVE. 21213 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ALBERT KRESKSI | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY UNKNOWN | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 217-50-7264 | | 17. INFORMANT ADDRESS CASPAR GROSS (HUSBAND) SAME ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY INSUFFICIENCY DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) HYPERTENSION; HASCVD | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 08-14, 1986, to 11-14, 1986, that (I) (we) lost saw the deceased alive on 01-14, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Cesar Gamboa M.D. | | | | DEGREE M.D. | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 01-20-86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. CESAR GAMBOA | | | | 22e. ADDRESS 3440 BELAIR RD. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 1/22/86 | | 23c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD. | | | | | |
| 24. FUNERAL DIRECTOR SCHIMUNEK FUNERAL HOME, INC. 3331 Brehms Lane, Balto. Md. 21213 | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 20 1986 REGISTRAR'S SIGNATURE | | | | | | | | | |

MEDICAL CERTIFICATION

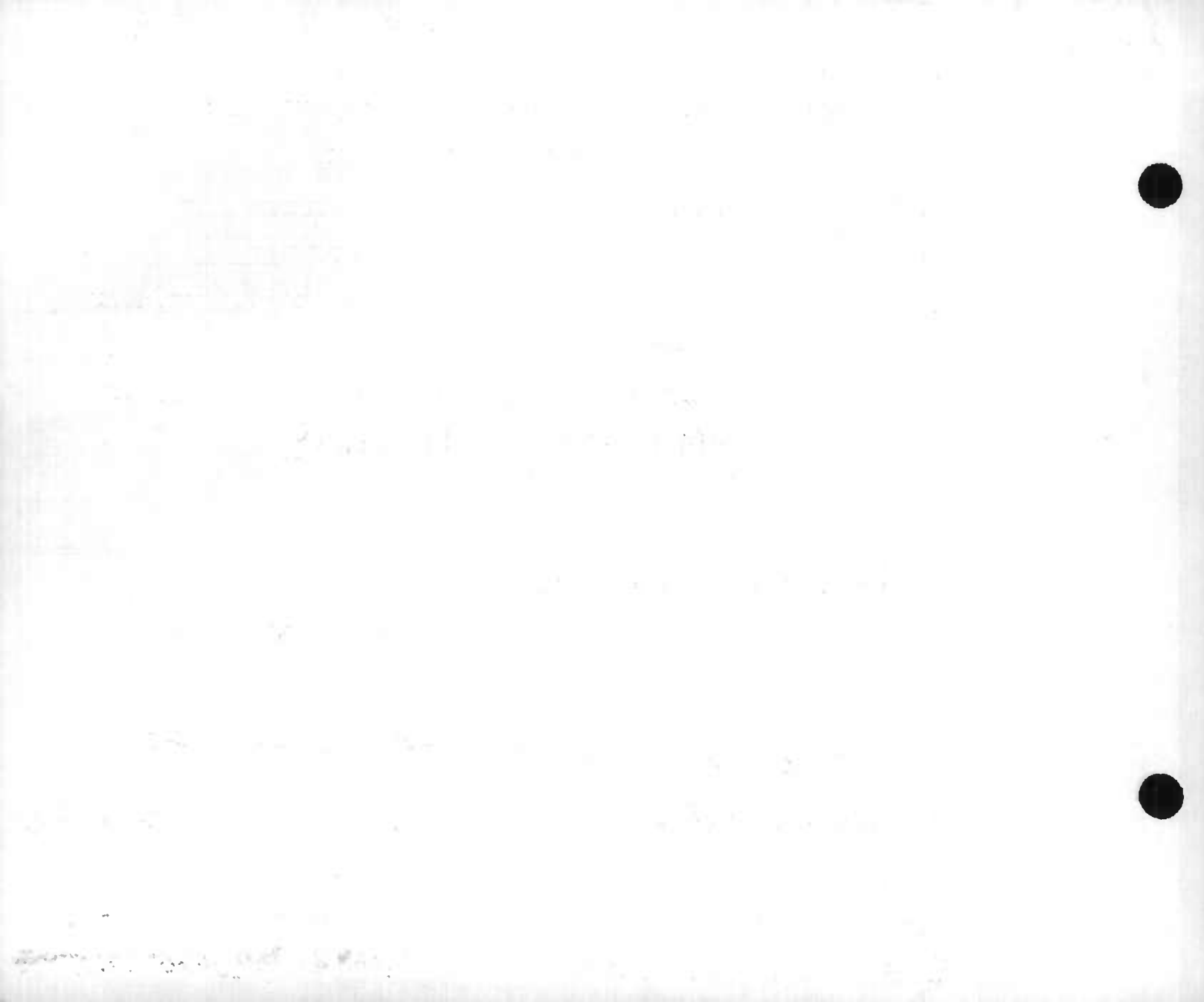
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and send them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | |
|--|--|---|---|---|---------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Rosa Lee Grubb | | | 2a. DATE OF DEATH MONTH DAY YEAR January 29, 1986 | | 2b. HOUR 2:15 ^A M | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 10 3 1911 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS | | 7. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 9b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 10. CITY OR TOWN OF DEATH Baltimore | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Belair Convalesarium | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Dundalk | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Jacob Burkett | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie Elliott | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | |
| 17. SOCIAL SECURITY NO. 216/12/3526 | | 18. INFORMANT Billie M. Friege | | 19. ADDRESS 7905 B Trappe Rd., Dundalk, Md. 21222 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF LUNG</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTASES FROM CA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>OF LUNG TO LIVER</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT HOME | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/30</u> , 19 <u>85</u> , to <u>1/25</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>1/25</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE <i>[Signature]</i> | | DEGREE | | 22c. DATE SIGNED 1/29/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Luis Rivera | | 22e. ADDRESS 5714 Harford Road Balto., Md. 21214 | | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 1/30/1986 | | 23c. NAME OF CEMETERY OR CREMATORY Green Mount Crematory | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | 24. FUNERAL DIRECTOR NAME Walter Brooks Bradley Inc. Balto., Md. 21222 | | 25a. DATE REC'D. BY REGISTRAR JAN 29 1986 | | |
| 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner requires notification.

90% COTTON FIBER

WILFRED DOWD



020251

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01097

FOR
1. STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) YAKA FIRST Thomas F. GUTHRIE LAST Franklin Thomas GUTHRIE | | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 13, 1986 | | 2b. HOUR 07:25 P.M. | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 13, 1942. | | 6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS. 43 YRS. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor | | 12b. KIND OF BUSINESS OR INDUSTRY Box Co. | |
| 13a. STATE Maryland | | 13b. COUNTY AA Co. | | 13c. CITY OR TOWN Glen Burnie | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Walter Guthrie | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie Marshall | | 13e. STREET ADDRESS / ZIP CODE 116 Garrett Rd. 21061 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 232.66.1341 | | 17. INFORMANT Wife ADDRESS Mrs. Jennie M. Guthrie Same as 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction. DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension DUE TO, OR AS A CONSEQUENCE OF (c) Exanguination. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Coronary artery disease | | | | | | | |
| 19a. DATE OF OPERATION 01.13.86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Hemorrhage post Bilac artery cath. | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1 P.M. 1 13 1986 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) Bilac art. cath. causing laceration. | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Cath. lab. | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Baltimore MD | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 01.03 19 86 , to 01.13 19 86 , that (I) (we) lost saw the deceased alive on 01.13.86 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Niels J. Linschoten | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 01.13.86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) NIELS J. LINSCHOTEN | | 22e. ADDRESS Johns Hopkins Hosp. Dept of Surgery. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Jan. 16, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn AA Co. Md. | |
| 24. FUNERAL DIRECTOR NAME Singleton Funeral Home | | ADDRESS Glen Burnie, Md. 21061 | | 25a. DATE REC'D. BY REGISTRAR JAN 16 1986 | | 25b. REGISTRAR'S SIGNATURE John Davidson-Randall | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL ATTENDING PHYSICIAN: THIS MEDICAL CERTIFICATE IS TO BE COMPLETED BY THE MEDICAL EXAMINER PRIOR TO BURIAL, CREMATION, OR REMOVAL OF THE DECEASED. IT IS TO BE FILED WITH THE STATE DEPT. OF HEALTH AND MENTAL HYGIENE. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE.

100000

2012 PLS
STREET LIGHTING
DIVISION

[Faint, illegible handwritten text and markings are visible across the page, including what appears to be a signature at the bottom left.]

022064

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|--|---|---|---------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RAYMOND HAAS | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 13 1986 | | 7b. HOUR 9:45am | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR NOV. 11 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3115 O'DONNELL ST. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STEEL WORKER | | 12b. KIND OF BUSINESS OR INDUSTRY STAINLESS STEEL | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. | | 13b. COUNTY - | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE 3115 O'DONNELL ST. 21224 | | 14. FATHER'S NAME FIRST MIDDLE LAST JOHN HAAS | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PEARL GRAY | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | |
| 16b. SOCIAL SECURITY NO. 214-01-6301 | | 17. INFORMANT EDMUND HAAS SR. (SON) | | ADDRESS 1518 BARKLEY AVE. 21221 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Esophageal Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic Esophageal Carcinoma PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0 | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR Nov 83 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 2711 Eastern Ave. Baltimore MD. | | 22a. I certify that (I) (my hospital) attended the deceased from Nov 83 to Dec 85 , that (I) (we) last saw the deceased alive on 12-19-85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE DR. MOHAMMED N. KHAN | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22d. ADDRESS 2711 Eastern Ave. | | 22e. DATE SIGNED 1/17/86 | | 22f. SIGNATURE DR. MOHAMMED N. KHAN | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 1/17/86 | | 23c. NAME OF CEMETERY OR CREMATORY OAK LAWN | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD. | |
| 24. FUNERAL DIRECTOR NAME SCHIMUNEK FUNERAL HOME, INC. | | 25a. DATE REC'D. BY REGISTRAR JAN 20 1986 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | 25c. SIGNATURE [Signature] | |

1. The first thing I noticed
when I got out of bed was

15 14 8

1/10/20

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

031211

| | | | | | |
|---|--|---|---|---|---|
| 1 DECEASED NAME (TYPE OR PRINT) HAGAN, MICHAEL EUGENE | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 25 86 | | 2b. HOUR 2:09pm |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 10 13 53 | | 6. AGE (IN YEARS LAST BIRTHDAY) 32 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore City | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Musician | | 12b. KIND OF BUSINESS OR INDUSTRY Music |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md. 13c. CITY OR TOWN Cecil 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE 1006 W. on Philadelphia 21901 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Kenneth E. Hagan | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Thelma L. Davis | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) Yes Vietnam | | 16b. SOCIAL SECURITY NO. 219-60-5732 | | 17. INFORMANT ADDRESS Karen Lynn Hagan 1006 W. on Philadelphia | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiogenic Shock DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/25/86 19 86 to 1/25 19 86 , that (I) (we) lost saw the deceased alive on _____ 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Stephen Plant | | DEGREE | | 22c. DATE SIGNED 1/25/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 01-28-86 | | 23c. NAME OF CEMETERY OR CREMATORY John Luther Miller Westminister Carroll Md. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE | | 23e. DATE REC'D. BY REGISTRAR | | 23f. REGISTRAR'S SIGNATURE Davidson | |
| 24. FUNERAL DIRECTOR NAME Eline Funeral Home Hampstead Md. 21074 | | 394 S. Main St. | | JAN 29 1986 | |

20% COTTON FIBER

JAN 2 1988

011158

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

011000

REG. NO.

| | | | | | | | |
|---|--|--|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) Oliver Milton Haines | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 7 86 | | | 2b. HOUR 100 P.M. | |
| 3. SEX MALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR 10 08 10 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GENL HOSP | | 12a. USUAL OCCUPATION (TYPE OF WORK OR NATURE OF WORKING LIFE) Iron Worker | | 12b. KIND OF BUSINESS OR INDUSTRY Construction | |
| 13a. STATE MD | | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS 31 W TALBOTT ST 21225 | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William B Haines | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Flora Gray | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II | | 17. INFORMANT FLORENCE V. HAINES | | | |
| | | 213-01-5140 | | ADDRESS Same as 13e | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOUS ANGIOMA DUE TO, OR AS A CONSEQUENCE OF (b) MALIGNANT MELANOMA DUE TO, OR AS A CONSEQUENCE OF (c) LIVER METASTASES | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/31/85, 1985, to 1/7, 1986, that (I) (we) last saw the deceased alive on 1/7, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Michael E. Collier, M.D. | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/7/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL E. COLLIER, M.D. | | | | 22e. ADDRESS 3001 SOUTH HANOVER ST. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/10/86 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto A.A. Md | |
| 24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hwy Balto Md | | | | 25a. DATE REC'D. BY REGISTRAR JAN 10 1986 | | 25b. REGISTRAR'S SIGNATURE John A. Anderson | |

100% COTTON FIBER

MADE IN U.S.A.



038006

STATE OF MARYLAND 8 6
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01101

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|---|--|--|---|--|----------------------------------|---|---|------------------------------------|---------|--|
| 1. DECEASED NAME (TYPE OR PRINT) HAIR, BO TINA | | | 2a. DATE OF DEATH MONTH DAY YEAR 1-27-86 | | | 2b. HOUR 3A M | | | | |
| 3. SEX F | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 1 27 86 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 3 | | IF UNDER 1 YEAR IF UNDER 24 HRS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) U.S.A | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PROVIDENT HOSPITAL INC | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NEW-BORN | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | | | 13b. COUNTY 1 | | 13c. CITY OR TOWN CITY | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST TINA HAIR | | | 16. STREET ADDRESS 2213 MT HOLLY ST, 21216 | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT MOTHER | | | | ADDRESS | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **IMMATURE, NON-VIABLE FETUS**DUE TO, OR AS A CONSEQUENCE OF **BORN AT 20-22 WEEKS GESTATION.**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c) **IMMATURITY**PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **—**

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION — | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR — P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) — | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) — | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE — | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-27-86 , 19 — , to 1-27-86 , 19 — , that we (we) lost — above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Ethel A. Adeloye | | | | DEGREE — | | 22c. DATE SIGNED — | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ETHEL A. ADELOYE MD | | | | 22e. ADDRESS PROVIDENT HOSPITAL INC. BALTIMORE | | | |

| | | | | | | | |
|--|--|-----------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE MD 21215 | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR FEB 06 1986 | | 25b. REGISTRAR'S SIGNATURE Davidson-Rodale | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove section 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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Handwritten notes or markings in the center of the page, possibly including the word "THREE".



07506

022028

1- FOR
STATE
REGISTRARSTATE OF MARYLAND 8 6 0 1 1 0 2
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

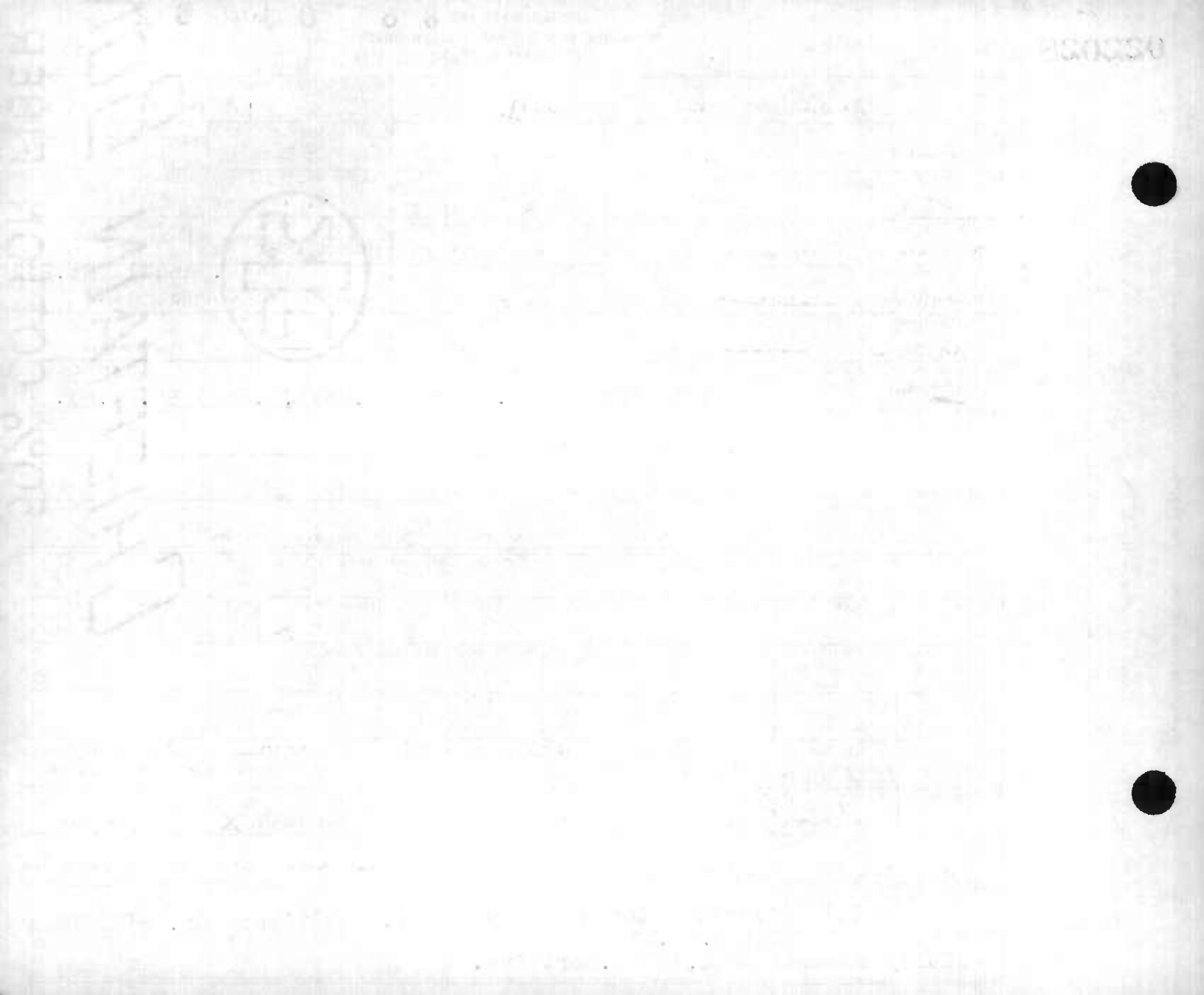
| | | | | | |
|--|---|---|---|---|--------------------|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA B HALL | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 - 14 86 | | 2b. HOUR 735 PM |
| 3. SEX FEMALE | 4. RACE CAUCASIAN | 5. DATE OF BIRTH MONTH DAY YEAR 6 19 03 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GEN'L HOSP | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | 13c. CITY OR TOWN BALTIMORE | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST MATTHEW ----- GREGUS | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA ----- DITTMAN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 213-036929 | | 17. INFORMANT ADDRESS Mr. Carroll L. Hall Jr. 3829 Bk. Av. Md. 21225 | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARCINOMA BREAST</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NO</u> | | | | | |
| MEDICAL CERTIFICATION | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-2</u> , 19 <u>85</u> , to <u>1-14</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>1/14</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Michael S. Collier, M.D.</u> | | DEGREE | | 22c. DATE SIGNED 1/14/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL S. Collier, M.D. | | 22e. ADDRESS 3001 S. HANOVER ST. BALTIMORE, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/18/86 | | 23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemt. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. Maryland | | 23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE JAN 20 1986 | | | |
| 24. FUNERAL DIRECTOR Balto. Md. 21230 McCully Funeral Home, 130 E. Fort Ave. | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the doctor certify that the deceased was under the care of the physician and that the certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove the top papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01103

036037

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) Lauretta M. Hall | | | 2a. DATE OF DEATH MONTH DAY YEAR January 31, 1986 | | 2b. HOUR M |
| 3 SEX Female | 4 RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 9 25 17 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH PLACE, GIVE STREET ADDRESS) 6008 AMBERWOOD ROAD APT. C 1 | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Hall | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Hall | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 215-16-1608 | | 17. INFORMANT ADDRESS Cynthia Dixon 6008 Amberwood ROAD Apt. C1 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Transitional Ca of Bladder</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Renal Failure</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min 7 months 3 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (this hospital) attended the deceased from <u>1/25</u> , 19 <u>86</u> , to <u>1/31</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>1/30</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Richard Bennett</u> DEGREE | | | | 22c. DATE SIGNED 1.31.86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard Bennett | | | | 22e. ADDRESS 5200 Eastern Ave | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 2/5/86 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery | |
| 23d. LOCATION CITY OR TOWN Baltimore, | | COUNTY Md. | | STATE | |
| 24. FUNERAL DIRECTOR NAME March Funeral Homes 1101 East North Avenue | | | | 25a. DATE REC'D. BY REGISTRAR FEB 03 1986 | |
| | | | | 25b. REGISTRAR'S SIGNATURE <u>W. Davidson-Randall</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical certificate must be signed by a physician.

007059

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1. STATE
REGISTRAR

| | | | | | |
|--|------------------|--|---|--|---------------------|
| 1. DECEASED NAME (TYPE OR PRINT) Ruth Mae Hall | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 2 86 | | 2b. HOUR 3 48 PM |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 2 02 1915 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 70 1/2 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD. | |
| 10. CITY OR TOWN OF DEATH Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deaton Medical Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress | |
| 13a. STATE Md. | | 13b. COUNTY | 13c. CITY OR TOWN Balto. | 13d. STREET ADDRESS / ZIP CODE 400 White lock ST 21217 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James Thomas | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl Morrow | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 238-03-5468 | | 17. INFORMANT Lois Rhee North Groh | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cancer of the tongue DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5 Nov 85 to Jan 86 that (I) (we) last saw the deceased alive on Jan 2 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE J.W. REEB M.D. | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/2/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J.W. REEB M.D. | | 22e. ADDRESS 6115 CHAS. ST - BALTO. MD. 21230 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b. DATE 1/2/86 | | 23c. NAME OF CEMETERY OR CREMATORY CLifton I | |
| 23d. LOCATION CITY OR TOWN South Carolina | | COUNTY | | STATE | |
| 24. FUNERAL DIRECTOR NAME Connelly Funeral Home of Dundalk | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR JAN 3 1986 | |
| | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

MEDICAL CERTIFICATION

A

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted.

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General 1st Grade 424
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General 5th Grade 424
General 6th Grade 424
General 7th Grade 424
General 8th Grade 424
General 9th Grade 424
General 10th Grade 424
General 11th Grade 424
General 12th Grade 424

007043

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01105

REG. NO.

| | | | | | | | |
|--|--|--|---|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) Evelyn Hamburger | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 - 1 - 86 | | | 2b. HOUR 11 13 A M | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR MAR. 27, 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore, Md. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK | |
| 12b. KIND OF BUSINESS OR INDUSTRY SOCIAL SECURITY | | | | | | | |
| 13a. STATE MARYLAND | | | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JULIUS CHERRY | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELEN MILLER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 217-09-5498 | | 17. INFORMANT BERNARD CHERRY APT. 401 6314 GREENSPRING AVE. BALTO., MD 21209 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Colon cancer - metastasis DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 30, 1985 to 1-1, 1986 , that (I) (we) lost saw the deceased alive on 1-1, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated about (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Daniel C Hagan, D.O. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | | 22c. DATE SIGNED 1/1/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Daniel C Hagan, D.O. | | | | 22e. ADDRESS Sinai Hospital of Baltimore | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE JAN. 2, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY HEBREW YOUNG MEN | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | 25a. DATE REC'D. BY REGISTRAR JAN 3 1986 25b. REGISTRAR'S SIGNATURE | | | |

12. BALTIMORE, MD.

MEDICAL CERTIFICATION

219

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND 8 6
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|---|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FRED D. HAMILTON Jr. | | | 2a. DATE OF DEATH MONTH 12 / DAY 14 / YEAR 86 | | | 2b. HOUR 950 P.M. | | | |
| 3. SEX MALE | | 4. RACE CAV. | | 5. DATE OF BIRTH MONTH 9 / DAY 15 / YEAR 37 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 48 YRS. | | IF UNDER 1 YEAR MONTHS 0 / DAYS 0 / HOURS 0 / MIN. 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENN. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV OF MD CANCER CTR | | | | 12a. USUAL OCCUPATION (INDUSTRY OR WORK OF MAINTENANCE) FOREMAN | | 12b. KIND OF BUSINESS OR INDUSTRY PHARMAC. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | | | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN DELMAR | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST FRED MIDDLE D. LAST HAMILTON | | | | 15. MOTHER'S MAIDEN NAME FIRST MILDRED MIDDLE MC LAST MANUS | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | | 16b. SOCIAL SECURITY NO. 1955-1963 | | 17. INFORMANT ADDRESS CAROLE A. HAMILTON DECEASED | | | |

| | | | |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | (b) RELAPSED CML | |
| | | (c) 4 wks | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from MARCH 85 to JAN 14 1986 , that (1) (we) lost saw the deceased alive on 1/14 1986 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Carla S. Alexander, MD DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 22c. DATE SIGNED 1/14/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CARLA S. ALEXANDER, MD | | | | 22e. ADDRESS UMH-UMCC, BALTIMORE | | | |

| | | | | | | | |
|---|--|-------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-18-1986 | | 23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park | | 23d. LOCATION CITY OR TOWN Salisbury COUNTY Wicomico STATE Maryland | |
| 24. FUNERAL DIRECTOR NAME MARVEL-SHORT | | | | ADDRESS Home DELMAR, MD | | 25a. DATE REC'D. BY REGISTRAR JAN 20 1986 | |
| 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return a carbon copy of page 3 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

030501

47



027082

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | |
|--|-------------------------|---|--|---|---------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) <i>Willie Mae Hamilton</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>01/19/86</i> | | 2b. HOUR M <i>4:45 PM</i> |
| 3. SEX <i>Female</i> | 4. RACE <i>Black</i> | 5. DATE OF BIRTH MONTH DAY YEAR <i>09 19 16</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>69</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>South Carolina</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Balt. City</i> MD | |
| 10. CITY OR TOWN OF DEATH <i>Balt. City</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>J. L. Deaton Medical Center</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Unemployed</i> | |
| 13a. STATE <i>M.d.</i> | | 13b. COUNTY <i>Baltimore</i> | | 13c. CITY OR TOWN <i>city</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Dan Ford</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Ozello Harper</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i> | |
| 16b. SOCIAL SECURITY NO. <i>218-18-6345</i> | | 17. INFORMANT ADDRESS <i>Mary Smith 1927 W. Mulberry St. 21223</i> | | | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer of the breast metastases</i> DUE TO, OR AS A CONSEQUENCE OF: (b) <i>Cancer of the Colon</i> DUE TO, OR AS A CONSEQUENCE OF: (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | | | |
|---|--|--|--|--|---|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>13 Dec.</i> 19 <i>85</i> to <i>19 Jan.</i> 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>19 Jan.</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>J.W. Reed M.D.</i> | | DEGREE <i>M.D.</i> | | 22c. DATE SIGNED <i>1/28/86</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J.W. REED</i> | | 22e. ADDRESS <i>611 S. CHAS. ST. BALTO. MD 21223</i> | | | |

| | | | |
|---|-----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | 23b. DATE <i>1/25/86</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>Church Cemetery</i> | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Winnabro S. C.</i> |
|---|-----------------------------|--|---|

| | | | |
|--|--------------------------------------|---|---|
| 24. FUNERAL DIRECTOR NAME <i>William C. March F/H West</i> | ADDRESS <i>4300 Wabash Avenue</i> | 25a. DATE REC'D. BY REGISTRAR <i>JAN 23 1986</i> | 25b. REGISTRAR'S SIGNATURE <i>Lelia Davidson-Randall</i> |
|--|--------------------------------------|---|---|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all other papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

01108

| | | | | | | | |
|--|--|--|--|--|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR P. | |
| Cordelia D. Hammel | | | | January 13, 1986 | | 7:20 M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS | |
| Female | | White | | May 15 1920 | | 65 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Md. | | U.S.A. | | | | Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | Union Memorial Hospital | | Housekeeper | | High School | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| Md. | | | | Baltimore | | 3204 Kenyon Ave. 21213 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | |
| William Hayes | | Nellie Allen | | no | | | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | |
| 216-12-7447 | | Edward Hammel (husband) | | same address | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>3 years</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), (b), OR (c), STATING THE UNDERLYING CAUSE LAST. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>months</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>diabetes mellitus, congestive heart failure</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>January 2, 1986</u> to <u>January 13, 1986</u> , that (I) (we) last saw the deceased alive on <u>January 13, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE OF PHYSICIAN (TYPE OR PRINT) | | | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | |
| <u>Dr. Wolf</u> | | | | <u>1/14/86</u> | | <u>Johns Hopkins Hospital</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | 1/18/86 | | Moreland Mem. Park | | Baltimore Md. | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE RECD. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Schimunek Funeral Home, Inc. 3331 Brehms Lane, Balto. Md. 21213 | | | | JAN 14 1986 | | <u>[Signature]</u> | |

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WATERFORD

NOV 20 1983

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|--|---|-------------------------|----------------------------------|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| FIRST MIDDLE LAST | | MONTH DAY YEAR | | HOURS MIN | |
| Byron S. Haney | | 1/16/86 | | 2:50 AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE | 7. IF UNDER 1 YEAR | |
| Male | White | MONTH DAY YEAR | 65 YRS. | MONTHS DAYS | HOURS MIN |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 9. CITIZEN OF WHAT COUNTRY? | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 11. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Pennsylvania | U.S.A. | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | Baltimore City MD. | | |
| 12. CITY OR TOWN OF DEATH | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 15. KIND OF BUSINESS OR INDUSTRY |
| Baltimore City | Frances Scott Key Hospital | | Steel Worker | | Beth. Steel |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | 17. STATE | 18. COUNTY | 19. CITY OR TOWN | 20. INSIDE CITY LIMITS? | 21. STREET ADDRESS / ZIP CODE |
| Maryland | Baltimore | Dundalk | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 235 Pinewood Road | 21222 |
| 22. FATHER'S NAME | 23. MOTHER'S MAIDEN NAME | | 24. ADDRESS | | |
| FIRST MIDDLE LAST | FIRST MIDDLE LAST | | 1907 Dineen Drive | | |
| Ferdinand | Esther | | Balto., MD. 21222 | | |
| 25. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 26. SOCIAL SECURITY NO. | 27. INFORMANT | | | |
| Yes | WW II | Charles A. Haney | | | |
| 28. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) Cardiac/pulmonary Arrest | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Adult Respiratory Distress Syndrome | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | |
| 29a. DATE OF OPERATION | 29b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 30a. AUTOPSY? | 30b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 31a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 31b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 31c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | | | | |
| 32a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 32b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 32c. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | |
| 33. I certify that (I) (this hospital) attended the deceased from 1/15/86 to 1/16/86, that (I) (we) lost | | | | | |
| saw the deceased alive on 1/16/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 34a. SIGNATURE | 34b. DEGREE | | 34c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 34d. DATE SIGNED |
| R. Healy | | | | | 1/16/86 |
| 35a. PHYSICIAN'S NAME (TYPE OR PRINT) | 35b. ADDRESS | | 36. DATE | | |
| Healy | Frances Soltke, Medical Center | | 1/20/1986 | | |
| 37a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 37b. DATE | 37c. NAME OF CEMETERY OR CREMATORY | 37d. LOCATION CITY OR TOWN | 37e. COUNTY | 37f. STATE |
| Burial | 1/20/1986 | Oak Lawn Cemetery | Baltimore | | Maryland |
| 38. FUNERAL DIRECTOR NAME | 38b. ADDRESS | | 39. JAN 21 1986 | | |
| Duda-Ruck, Inc. | 7922 Wise Avenue Dundalk, Maryland 21222 | | REGISTERED BY REGISTER'S SIGNATURE | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies: Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

035120

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01110

REG. NO.

| | | | | | | | | |
|--|--|--|---|---|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VERA N. Hann | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 29 86 | | | 2b. HOUR 9:45 AM | | |
| 3. SEX FEMALE | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR 6 21 84 | | 6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BOOKKEEPER AT | | |
| 12b. KIND OF BUSINESS OR INDUSTRY LUMBER CO. | | 13a. STREET ADDRESS / ZIP CODE 35 Chabworth Ave 21136 | | | | | | |
| 13b. STATE MD | | 13c. CITY OR TOWN BALTO. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 35 Chabworth Ave 21136 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WALTER R. NAYLOR SR. | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MATTIE BROTHERS | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-149616 | | 17. INFORMANT ADDRESS MR. WALTER B. HANN REISTERSTOWN, MD. | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Breast Carcinoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a WBC ↓↓, Platelets ↓↓ | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (i) (this hospital) attended the deceased from 1/29 86 to 1/29 86, and that (ii) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so say the responsible on above.) | | | | | | | | |
| 22b. SIGNATURE Pink Goldstein MD | | | | DEGREE | | 22c. DATE SIGNED 1/29/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Goldstein | | | | 22e. ADDRESS SINAI HOSPITAL | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE FEB. 1, 86 | | 23c. NAME OF CEMETERY OR CREMATORY ALL SAINTS CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE REISTERSTOWN, MD. | | |
| 24. FUNERAL DIRECTOR ELINE FUNERAL HOME REISTERSTOWN, MD. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 31 1986 | | 25b. REGISTRAR'S SIGNATURE J. Davidson-Randall | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the instructions on the reverse, it should be detached for use as the burial permit. Then please remove the appropriate Page 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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CHALF

BALTIMORE CITY

X

BOOKKEEPER AT LUMBER CO.

BALTO. R. I. TOWN

WALTER R. NAYLOR SR. MATTIE BROTHENS

NO. 100 - R. WALTER B. HANN REISTERSTOWN, MD.

DEPT. OF ALL SAINTS CEMETERY REISTERSTOWN, MD.

LINE FURNAL HOME REISTERSTOWN, MD.

022040

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove confidential pages. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|---|--|--|--|---|---------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MILDRED D. HANSEL | | | 2a. DATE OF DEATH MONTH DAY YEAR 1-17-86 | | 2b. HOUR 5:15 AM | |
| 3. SEX FEMALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR 05 02 1919 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS. | | 7. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARried <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST AGNES HOSPITAL | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK | | 12b. KIND OF BUSINESS OR INDUSTRY A & P CO. | | 13. STREET ADDRESS / ZIP CODE 2049 HARMAN AVE. 21230 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST CHARLES WHEATLEY | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAY STARKE | | 16. SOCIAL SECURITY NO. 215-09-1761 | | |
| 17. INFORMANT LEONARD HANSEL | | 18. ADDRESS 2049 HARMAN AVE. 21230 | | 19. DATE OF OPERATION | | |
| 20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 22. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | |
| 23. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 24. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 25. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 26. I certify that (I) (this hospital) attended the deceased from 12/26/85, 19 85, to 1/17, 19 86, that (I) (we) last saw the deceased alive on 1/17, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | |
| 27. SIGNATURE Moonhee Lee | | 28. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 29. DATE SIGNED 1/17/86 | | |
| 30. PHYSICIAN'S NAME (TYPE OR PRINT) Lee, Moonhee | | 31. ADDRESS St. Agnes Hospital | | 32. DATE REC'D. BY REGISTRAR JAN 20 1986 | | |
| 33. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 34. DATE 01-20-86 | | 35. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEM. | | |
| 36. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC. | | 37. ADDRESS 21229 4107 WILKENS AVE. | | 38. REGISTRAR'S SIGNATURE Jana Harrison | | |

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Film G612 item 5,6 2/25/86 rja

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01112

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | |
|---|--|--|---|--|---|---|
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST KATIE HARCUM | | | 2a DATE OF DEATH MONTH DAY YEAR 01 13 86 | | 2b HOUR 1:20 PM | |
| 3 SEX Female | | 4 RACE Black | | 5 DATE OF BIRTH MONTH DAY YEAR 9/20/1912 | | 6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina | | 7b CITIZEN OF WHAT COUNTRY? U. S. A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. |
| 10 CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 13a STATE Maryland | | 13b COUNTY Baltimore | | 13c CITY OR TOWN Baltimore | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14 FATHER'S NAME FIRST MIDDLE LAST John Walker | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Kornegay | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | |
| 16b SOCIAL SECURITY NO. 215-24-7556 | | 17 INFORMANT ADDRESS Hubert L. Faison 2219 Monroe St. Balto 21217 | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Colon Cancer DUE TO, OR AS A CONSEQUENCE OF (b) Metastasis to Thoracic Spine/Paraparesis 12/85 DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (s) (this hospital) attended the deceased from 12/26 19 86 , to 1/13 19 86 , that (I) (we) last saw the deceased alive on 1/13 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE Dana L. Simpler MD | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/13/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SIMPLER MD | | 22e. ADDRESS MERCY HOSPITAL | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-18-86 | | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus Maryland |
| 24 FUNERAL DIRECTOR NAME ADDRESS Bailey-Douglass Funeral Home 1348 N. Calhoun St. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 16 1986 | | |
| 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



031036

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST Roy | | MIDDLE Theodore | | LAST HARE | | 2a. DATE OF DEATH MONTH DAY YEAR 01 21 86 | | 2b. HOUR 0945 M | |
| 3. SEX male | | 4. RACE Cauc. | | 5. DATE OF BIRTH MONTH DAY YEAR 05 16 02 | | 6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS. | | IF UNDER 1 YEAR MONTHS DAYS 83 | | IF UNDER 74 HRS. HOURS MIN. 0945 | |
| 7a. BIRTHPLACE COUNTRY USA A-Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union City of Maryland Hosp. | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | | | | | | 13b. COUNTY ALLEGANY | | 13c. CITY OR TOWN Cumberland | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE 810 Memorial Ave 4502 | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Thomas Hare | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nancy J. Dyke | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | | | 16b. SOCIAL SECURITY NO. 214 32 2958 | | 17. INFORMANT old records. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiopulmonary arrest. DUE TO, OR AS A CONSEQUENCE OF (b) multiple organ failure. DUE TO, OR AS A CONSEQUENCE OF (c) generalized sepsis. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 minute 10 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a transitional cell carcinoma of bladder. | | | | | | | | | | | |
| 19a. DATE OF OPERATION 12/26/85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED breakdown of ileal loop 5999 | | | | 19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec 10 19 85 , to Jan 21 19 86 , that (I) (we) last saw the deceased alive on Jan 21 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Sam H. Wells | | DEGREE MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 1/21/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY H WELLS | | | | 22e. ADDRESS 22 S Greene St. Baltimore | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE JAN 24 1986 | | 23c. NAME OF CEMETERY OR CREMATORY HILLCREST BURIAL PARK | | 23d. LOCATION CITY OR TOWN COUNTY STATE CUMBERLAND ALLEGANY MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MARYLAND | | | | 25a. DATE REC'D. BY REGISTRAR 1/27/86 | | 25b. REGISTRAR'S SIGNATURE John B. ... | | | | | |

MEDICAL CERTIFICATION

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | |
|--|--|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) WARREN James HARGROVE SR | | 2a. DATE OF DEATH MONTH DAY YEAR 1-21-86 | | 2b. HOUR M 11 |
| 3. SEX male | 4. RACE col | 5. DATE OF BIRTH MONTH DAY YEAR 11 4 31 | 6. AGE (IN YEARS (LAST BIRTHDAY)) 54 YRS | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 54 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore Md | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Providence Hosp. | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer | 12b. KIND OF BUSINESS OR INDUSTRY Dept Ed. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Willie Watkins | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth HARGROVE | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | |
| 16b. SOCIAL SECURITY NO. 213-26-6615 | | 17. INFORMANT ADDRESS Mrs. Jane Hargrove 2825 Parkwood Ave. 21217 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Heart Disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH / |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | |
| 19a. DATE OF OPERATION 12/21/85 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Coronary Artery Bypass | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8:00 P.M. 12 21 85 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) Heart Attack | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Home | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 600 Reisterstown Rd Baltimore Co. Md. | | |
| 22a. I certify that (I) (this hospital) attended the deceased from December 1985 to present 19____, that (I) (we) last saw the deceased alive on 10/21/85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE C. GAKUBA | DEGREE MD | 22c. DATE SIGNED 1/21/86 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. GAKUBA |
| 22e. ADDRESS 600 Reisterstown Rd Baltimore Co. Md. | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | |
| 23b. DATE 1-24-86 | 23c. NAME OF CEMETERY OR CREMATORY Garrison Forest | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. Md. | 24. FUNERAL DIRECTOR NAME ADDRESS Joseph L. Russ 2222 W. North Ave | |
| 25a. DATE REC'D. BY REGISTRAR JAN 24 1986 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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[Faint, illegible text throughout the page, likely bleed-through from the reverse side. The text appears to be organized into several paragraphs.]

034022

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|--|--|---|--|---|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Dorothy May Harmon | | | 2a DATE OF DEATH MONTH DAY YEAR JAN 28 1985 | | 2b HOUR 4:20 AM | | | | |
| 3 SEX Female | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR February 1, 1912 | | 6 AGE (IN YEARS (LAST BIRTHDAY)) 73 YRS IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN. | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Fairmont, W. Va. | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10 CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress | | 12b KIND OF BUSINESS OR INDUSTRY Holiday Inn | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland | | 13b COUNTY A. A. Co. | | 13c CITY OR TOWN Glen Burnie | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET ADDRESS / ZIP CODE 405 4th Street N.W. 21061 | |
| 14 FATHER'S NAME FIRST MIDDLE LAST John McFadden | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sadie Hess | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b SOCIAL SECURITY NO. N/A | | 17 INFORMANT (daughter) ADDRESS Mrs. Elvera A. Bair Same as 13 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Central Nervous System Collapse DUE TO, OR AS A CONSEQUENCE OF (b) Cardiopulmonary Arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Ventricular Tachycardia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from JAN 27 , 19 85 , to JAN 28 , 19 85 that (I) (we) last saw the deceased alive on JAN 27 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE Scott Rifkin | | DEGREE MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c DATE SIGNED Jan 28, 1985 | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Scott Rifkin, M.D. | | | | 22e ADDRESS Union Memorial Hospital | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b DATE Jan. 30, 1986 | | 23c NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk. | | 23d LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Md. | | | |
| 24 FUNERAL DIRECTOR NAME R. H. Rifkin ADDRESS Singleton Funeral Home Glen Burnie, Maryland | | | | 25a DATE REC'D. BY REGISTRAR JAN 30 1985 | | 25b REGISTRAR'S SIGNATURE Julia Gordon-Rifkin | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. Page 4 shows any injury, or other traumatic event, the medical examiner should be notified of. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified of.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. The permit should be removed from the certificate, signed by the funeral director, and should be detached for use as the burial-transit permit. The permit should be removed from the certificate, signed by the funeral director, and should be detached for use as the burial-transit permit. The permit should be removed from the certificate, signed by the funeral director, and should be detached for use as the burial-transit permit.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) ALFONSO C HARRINGTON | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 1, 1986 | | | 2b. HOUR P M 4:23 | | | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 1-30-63 | | 6. AGE (IN YEARS LAST BIRTHDAY) 22 YRS | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Maryland | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Leo C. Harrington | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gloria Harrington | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 216-86-5680 | |
| 17. INFORMANT ADDRESS Gloria Harrington 1818 E. Fayette St. 21231 | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Steroid Therapy for Systemic Lupus Erythematosus</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>DECEMBER 31, 1985</u> to <u>JAN 1, 1986</u> , that (I) (we) last saw the deceased alive on <u>JAN 1, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Walter N. Kernan</u> | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <u>1/1/86</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Walter N. Kernan</u> | | | | 22e. ADDRESS <u>5/ Johns Hopkins Hospital</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>1-6-86</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u> | | 23d. LOCATION CITY OR TOWN COUNTY <u>Baltimore, Maryland</u> | | | |
| 24. FUNERAL DIRECTOR NAME <u>Bailey-Douglass Funeral Home 1348 N. Calhoun St.</u> | | | | 25a. DATE REC'D. BY REGISTRAR <u>JAN 16 1986</u> | | | | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | | | | | |
|--|---------|--|------------------|--|--|---|--|-----------------------------------|-----------------|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR | |
| Andrea R. Harris Jr. | | | | | 1 | | 13 | 86 | 11:15 | | AM |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | |
| Male | Black | | 12 11 75 | | 10 YRS | | MONTHS DAYS | | HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | | USA | | | | Baltimore City MD | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | University of Maryland Hsp | | | | child | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | | |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 117 N Schroeder St 21223 | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| FIRST MIDDLE LAST | | | | | FIRST MIDDLE LAST | | | | | | |
| Percy M. Dunnock | | | | | Dianne Green | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | |
| No | | | | | 212-98-3213 | | DIANE DUNNOCK 117 N. Schroeder | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>respiratory cardiac arrest</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) <u>aspiration possible</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | |
| <u>cerebral palsy</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | STREET | | CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>1/13/86</u> to <u>1/13/86</u> that (1) (we) last saw the deceased alive on <u>1/13/86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | 22c. DATE SIGNED | | | | | |
| Kevin D. Phillips | | | | ATTENDING MEDICAL STAFF | | 1/13/86 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| Kevin D. Phillips | | | | 22 S Greene St | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (IF ANY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | |
| Burial | | 1-17-86 | | Cedar Hill | | Anne Arundel Md. | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| W.M.C. March F.H. Inc. 1101 E North Ave | | | | | | JAN 16 1986 | | | | | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies, Pages 1 and 2, and take them to the funeral home within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted at once.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

| | | | |
|---|---|--|---|
| 1- FOR STATE REGISTRAR | | REG. NO. | |
| 1 DECEASED NAME (TYPE OR PRINT) | | 2a DATE OF DEATH | |
| FIRST MIDDLE LAST ANNA MAXINE HARRIS | | MONTH DAY YEAR HOUR 1/30/86 M | |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH | 6 AGE (IN YEARS LAST BIRTHDAY) |
| Female | Black | MONTH DAY YEAR 9/23/16 | 67 69 YRS |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b CITIZEN OF WHAT COUNTRY? | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH |
| Maryland | USA | | BAUT City MD. |
| 10 CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET) | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b KIND OF BUSINESS OR INDUSTRY |
| BAUT. | Bon Secours Hospital | Homemaker | Home |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | 13b COUNTY | 13c CITY OR TOWN | 13d INSIDE CITY LIMITS? |
| STATE MA | | BAUT | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14 FATHER'S NAME | 15 MOTHER'S MAIDEN NAME | 13e STREET ADDRESS / ZIP CODE | |
| FIRST MIDDLE LAST Harvey Leroy Turner | FIRST MIDDLE LAST Genevieve O. Douglass | 3800 W. Belvedere Ave. Baltimore, Maryland 21215 | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | 17 INFORMANT | ADDRESS |
| No. | 244-12-9835 | Mrs. Alice Gwynn | 2521 Jonathan Road Ellicott City, Md. 21043 |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Myocardial infarction | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | |
| (b) Congestive heart failure | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | |
| (c) | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | |
| Recent fracture | | | |
| 19a DATE OF OPERATION | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a AUTOPSY? | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/27/86, 19 to 1/30/86 that (I) (we) lost saw the deceased alive on 1/30/86, 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE | | DEGREE | TITLE DATE SIGNED |
| [Signature] | | MD | 1/30/86 |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e ADDRESS | |
| [Signature] | | 9057 BAUT MAR PIKE ETC MD | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b DATE | 23c NAME OF CEMETERY OR CREMATORY | 23d LOCATION CITY OR TOWN COUNTY STATE |
| Burial | 02/05/1986 | Arbutus Memorial Park | Baltimore, Maryland |
| 24 FUNERAL DIRECTOR NAME ADDRESS | | 25a DATE REC'D BY REGISTRAR | |
| Funeral & Sons Funeral Home, Inc. 2501 Gwynn Falls Pkwy. Baltimore, Md. 21216 | | FEB 03 1986 | |
| | | 25b REGISTRAR'S SIGNATURE | |
| | | [Signature] | |

OK COTTON FIELD
FEB 11 1900



RECEIVED

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FEB 11 1900

0091/51

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH INSTRUCTIONS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|--|--------------------------------------|---|--|
| 1- FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| FIRST MIDDLE LAST | | DATE OF DEATH | | HOUR | |
| CHARLES E. HARRIS | | 1 5 19 86 | | 7:04 | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (IN YEARS) | 7a. DATE OF DEATH | 7b. HOUR |
| Male | White | 10 7 21 | 64 YRS. | 1 5 19 86 | 7:04 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Maryland | USA | WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | Baltimore City | | |
| 10 CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | 3501 Elm Ave. 21211 | Retired | | | |
| 13a. STATE | 13b. CITY OR TOWN | 13c. INSIDE CITY LIMITS? | 13d. STREET ADDRESS | | |
| Maryland | Baltimore | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 3501 Elm Avenue 21211 | | |
| 14 FATHER'S NAME | 15 MOTHER'S MAIDEN NAME | | | | |
| FIRST MIDDLE LAST | FIRST MIDDLE LAST | | | | |
| Clarence Harris | (unknown) | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16b. SOCIAL SECURITY NO. | 17 INFORMANT | ADDRESS | | |
| yes (YES, NO, OR UNKNOWN) | WW II | Jack Morgan | 3501 Elm Ave. 21211 | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) Chronic obstructive pulmonary disease | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| | | HOUR A.M. MONTH DAY YEAR | | | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> | | | | STREET CITY OR TOWN COUNTY STATE | |
| AT WORK <input type="checkbox"/> | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | |
| Ann M. Dixon, M.D. | | M.D. Assistant MEDICAL EXAMINER | | 1-6-86 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | |
| Ann M. Dixon, M.D. | | 111 Penn St., Balto., MD 21201 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Cremation | | 1/7/86 | | Green Mount Cemetery | |
| | | | | Baltimore | |
| | | | | Maryland | |
| 24 FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| NAME ADDRESS | | JAN 7 1986 | | | |
| A. Alan Seitz, Jr. 3818 Roland Ave. 21211 | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND 8 6 0 1 1 2 0 | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | |
| Deebee | | | | | | Harris | | 1 21 86 | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7b HOUR | |
| Male | | Black | | 7 19 22 | | 63 YRS. | | 1:15 pm | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | |
| N. C. | | USA | | | | Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Balto. City | | St. Agnes Hospital | | | | Retired | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a STATE | | 13b COUNTY | | 13c. CITY OR TOWN | | 13d STREET ADDRESS / ZIP CODE | | 21229 | |
| Md. | | Baltimore | | Baltimore | | 203 Atholgate Lane Apt D | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | |
| Jake | | Harris | | Valaria | | Thomas | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT ADDRESS | | | | | |
| NO | | 231285963 | | Iantha Harris 203 Atholgate Lane Apt D | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cardio pulmonary arrest | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| CA & Bleeding from external gunshot. 1° to webster | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | |
| 4429-1991 | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| 1985-85 | | Laryngeal CA. | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-21-86 to 1-21-86, that (I) (we) lost | | | | | | | | | |
| saw the deceased alive on 1-21-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | | | |
| Khalil Freij | | | | 1-21-86 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e ADDRESS | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | |
| T KHALIL FREIJ | | 5011 Goo CATON AVE | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | 1-25-86 | | King Memorial | | Randallstown Md | | | |
| 24 FUNERAL DIRECTOR NAME | | | | 25a DATE REC'D. BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | | |
| WM. C. March F.H. 4300 Wabash Ave. | | | | JAN 23 1986 | | John Davidson | | | |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 01121 | | | |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST Hilda A. Harris | | 2a. DATE OF DEATH MONTH DAY YEAR 01 03 86 | | 2b. HOUR 10:30P _M | |
| 3. SEX FEmale | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 1 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Med. Cen. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY - | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Herman Voss | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Giese | | 13e. STREET ADDRESS 404 S. Clinton St. 21224 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-22-3149 | | 17. INFORMANT ADDRESS 3527 McShane Way Vivian Lindenau (dghtr) 21222 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>complete heart block, hypothermia</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/20/85</u> , 19 <u>85</u> , to <u>1/3/86</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>1/3/86</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Stanley D. Drake, MD</u> | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/3/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stanley D. Drake, MD | | | | 22e. ADDRESS 4940 Eastern Ave. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/6/86 | | 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | |
| 24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane, Balto. Md. 21213 | | | | 25a. DATE REC'D. BY REGISTRAR 9-1086 | | 25b. REGISTRAR'S SIGNATURE <u>Davidson-Rodell</u> | |

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185 | 186 | 187 | 188 | 189 | 190 | 191 | 192 | 193 | 194 | 195 | 196 | 197 | 198 | 199 | 200 | 201 | 202 | 203 | 204 | 205 | 206 | 207 | 208 | 209 | 210 | 211 | 212 | 213 | 214 | 215 | 216 | 217 | 218 | 219 | 220 | 221 | 222 | 223 | 224 | 225 | 226 | 227 | 228 | 229 | 230 | 231 | 232 | 233 | 234 | 235 | 236 | 237 | 238 | 239 | 240 | 241 | 242 | 243 | 244 | 245 | 246 | 247 | 248 | 249 | 250 | 251 | 252 | 253 | 254 | 255 | 256 | 257 | 258 | 259 | 260 | 261 | 262 | 263 | 264 | 265 | 266 | 267 | 268 | 269 | 270 | 271 | 272 | 273 | 274 | 275 | 276 | 277 | 278 | 279 | 280 | 281 | 282 | 283 | 284 | 285 | 286 | 287 | 288 | 289 | 290 | 291 | 292 | 293 | 294 | 295 | 296 | 297 | 298 | 299 | 300 | 301 | 302 | 303 | 304 | 305 | 306 | 307 | 308 | 309 | 310 | 311 | 312 | 313 | 314 | 315 | 316 | 317 | 318 | 319 | 320 | 321 | 322 | 323 | 324 | 325 | 326 | 327 | 328 | 329 | 330 | 331 | 332 | 333 | 334 | 335 | 336 | 337 | 338 | 339 | 340 | 341 | 342 | 343 | 344 | 345 | 346 | 347 | 348 | 349 | 350 | 351 | 352 | 353 | 354 | 355 | 356 | 357 | 358 | 359 | 360 | 361 | 362 | 363 | 364 | 365 | 366 | 367 | 368 | 369 | 370 | 371 | 372 | 373 | 374 | 375 | 376 | 377 | 378 | 379 | 380 | 381 | 382 | 383 | 384 | 385 | 386 | 387 | 388 | 389 | 390 | 391 | 392 | 393 | 394 | 395 | 396 | 397 | 398 | 399 | 400 | 401 | 402 | 403 | 404 | 405 | 406 | 407 | 408 | 409 | 410 | 411 | 412 | 413 | 414 | 415 | 416 | 417 | 418 | 419 | 420 | 421 | 422 | 423 | 424 | 425 | 426 | 427 | 428 | 429 | 430 | 431 | 432 | 433 | 434 | 435 | 436 | 437 | 438 | 439 | 440 | 441 | 442 | 443 | 444 | 445 | 446 | 447 | 448 | 449 | 450 | 451 | 452 | 453 | 454 | 455 | 456 | 457 | 458 | 459 | 460 | 461 | 462 | 463 | 464 | 465 | 466 | 467 | 468 | 469 | 470 | 471 | 472 | 473 | 474 | 475 | 476 | 477 | 478 | 479 | 480 | 481 | 482 | 483 | 484 | 485 | 486 | 487 | 488 | 489 | 490 | 491 | 492 | 493 | 494 | 495 | 496 | 497 | 498 | 499 | 500 | 501 | 502 | 503 | 504 | 505 | 506 | 507 | 508 | 509 | 510 | 511 | 512 | 513 | 514 | 515 | 516 | 517 | 518 | 519 | 520 | 521 | 522 | 523 | 524 | 525 | 526 | 527 | 528 | 529 | 530 | 531 | 532 | 533 | 534 | 535 | 536 | 537 | 538 | 539 | 540 | 541 | 542 | 543 | 544 | 545 | 546 | 547 | 548 | 549 | 550 | 551 | 552 | 553 | 554 | 555 | 556 | 557 | 558 | 559 | 560 | 561 | 562 | 563 | 564 | 565 | 566 | 567 | 568 | 569 | 570 | 571 | 572 | 573 | 574 | 575 | 576 | 577 | 578 | 579 | 580 | 581 | 582 | 583 | 584 | 585 | 586 | 587 | 588 | 589 | 590 | 591 | 592 | 593 | 594 | 595 | 596 | 597 | 598 | 599 | 600 | 601 | 602 | 603 | 604 | 605 | 606 | 607 | 608 | 609 | 610 | 611 | 612 | 613 | 614 | 615 | 616 | 617 | 618 | 619 | 620 | 621 | 622 | 623 | 624 | 625 | 626 | 627 | 628 | 629 | 630 | 631 | 632 | 633 | 634 | 635 | 636 | 637 | 638 | 639 | 640 | 641 | 642 | 643 | 644 | 645 | 646 | 647 | 648 | 649 | 650 | 651 | 652 | 653 | 654 | 655 | 656 | 657 | 658 | 659 | 660 | 661 | 662 | 663 | 664 | 665 | 666 | 667 | 668 | 669 | 670 | 671 | 672 | 673 | 674 | 675 | 676 | 677 | 678 | 679 | 680 | 681 | 682 | 683 | 684 | 685 | 686 | 687 | 688 | 689 | 690 | 691 | 692 | 693 | 694 | 695 | 696 | 697 | 698 | 699 | 700 | 701 | 702 | 703 | 704 | 705 | 706 | 707 | 708 | 709 | 710 | 711 | 712 | 713 | 714 | 715 | 716 | 717 | 718 | 719 | 720 | 721 | 722 | 723 | 724 | 725 | 726 | 727 | 728 | 729 | 730 | 731 | 732 | 733 | 734 | 735 | 736 | 737 | 738 | 739 | 740 | 741 | 742 | 743 | 744 | 745 | 746 | 747 | 748 | 749 | 750 | 751 | 752 | 753 | 754 | 755 | 756 | 757 | 758 | 759 | 760 | 761 | 762 | 763 | 764 | 765 | 766 | 767 | 768 | 769 | 770 | 771 | 772 | 773 | 774 | 775 | 776 | 777 | 778 | 779 | 780 | 781 | 782 | 783 | 784 | 785 | 786 | 787 | 788 | 789 | 790 | 791 | 792 | 793 | 794 | 795 | 796 | 797 | 798 | 799 | 800 | 801 | 802 | 803 | 804 | 805 | 806 | 807 | 808 | 809 | 810 | 811 | 812 | 813 | 814 | 815 | 816 | 817 | 818 | 819 | 820 | 821 | 822 | 823 | 824 | 825 | 826 | 827 | 828 | 829 | 830 | 831 | 832 | 833 | 834 | 835 | 836 | 837 | 838 | 839 | 840 | 841 | 842 | 843 | 844 | 845 | 846 | 847 | 848 | 849 | 850 | 851 | 852 | 853 | 854 | 855 | 856 | 857 | 858 | 859 | 860 | 861 | 862 | 863 | 864 | 865 | 866 | 867 | 868 | 869 | 870 | 871 | 872 | 873 | 874 | 875 | 876 | 877 | 878 | 879 | 880 | 881 | 882 | 883 | 884 | 885 | 886 | 887 | 888 | 889 | 890 | 891 | 892 | 893 | 894 | 895 | 896 | 897 | 898 | 899 | 900 | 901 | 902 | 903 | 904 | 905 | 906 | 907 | 908 | 909 | 910 | 911 | 912 | 913 | 914 | 915 | 916 | 917 | 918 | 919 | 920 | 921 | 922 | 923 | 924 | 925 | 926 | 927 | 928 | 929 | 930 | 931 | 932 | 933 | 934 | 935 | 936 | 937 | 938 | 939 | 940 | 941 | 942 | 943 | 944 | 945 | 946 | 947 | 948 | 949 | 950 | 951 | 952 | 953 | 954 | 955 | 956 | 957 | 958 | 959 | 960 | 961 | 962 | 963 | 964 | 965 | 966 | 967 | 968 | 969 | 970 | 971 | 972 | 973 | 974 | 975 | 976 | 977 | 978 | 979 | 980 | 981 | 982 | 983 | 984 | 985 | 986 | 987 | 988 | 989 | 990 | 991 | 992 | 993 | 994 | 995 | 996 | 997 | 998 | 999 | 1000 | 1001 | 1002 | 1003 | 1004 | 1005 | 1006 | 1007 | 1008 | 1009 | 1010 | 1011 | 1012 | 1013 | 1014 | 1015 | 1016 | 1017 | 1018 | 1019 | 1020 | 1021 | 1022 | 1023 | 1024 | 1025 | 1026 | 1027 | 1028 | 1029 | 1030 | 1031 | 1032 | 1033 | 1034 | 1035 | 1036 | 1037 | 1038 | 1039 | 1040 | 1041 | 1042 | 1043 | 1044 | 1045 | 1046 | 1047 | 1048 | 1049 | 1050 | 1051 | 1052 | 1053 | 1054 | 1055 | 1056 | 1057 | 1058 | 1059 | 1060 | 1061 | 1062 | 1063 | 1064 | 1065 | 1066 | 1067 | 1068 | 1069 | 1070 | 1071 | 1072 | 1073 | 1074 | 1075 | 1076 | 1077 | 1078 | 1079 | 1080 | 1081 | 1082 | 1083 | 1084 | 1085 | 1086 | 1087 | 1088 | 1089 | 1090 | 1091 | 1092 | 1093 | 1094 | 1095 | 1096 | 1097 | 1098 | 1099 | 1100 | 1101 | 1102 | 1103 | 1104 | 1105 | 1106 | 1107 | 1108 | 1109 | 1110 | 1111 | 1112 | 1113 | 1114 | 1115 | 1116 | 1117 | 1118 | 1119 | 1120 | 1121 | 1122 | 1123 | 1124 | 1125 | 1126 | 1127 | 1128 | 1129 | 1130 | 1131 | 1132 | 1133 | 1134 | 1135 | 1136 | 1137 | 1138 | 1139 | 1140 | 1141 | 1142 | 1143 | 1144 | 1145 | 1146 | 1147 | 1148 | 1149 | 1150 | 1151 | 1152 | 1153 | 1154 | 1155 | 1156 | 1157 | 1158 | 1159 | 1160 | 1161 | 1162 | 1163 | 1164 | 1165 | 1166 | 1167 | 1168 | 1169 | 1170 | 1171 | 1172 | 1173 | 1174 | 1175 | 1176 | 1177 | 1178 | 1179 | 1180 | 1181 | 1182 | 1183 | 1184 | 1185 | 1186 | 1187 | 1188 | 1189 | 1190 | 1191 | 1192 | 1193 | 1194 | 1195 | 1196 | 1197 | 1198 | 1199 | 1200 | 1201 | 1202 | 1203 | 1204 | 1205 | 1206 | 1207 | 1208 | 1209 | 1210 | 1211 | 1212 | 1213 | 1214 | 1215 | 1216 | 1217 | 1218 | 1219 | 1220 | 1221 | 1222 | 1223 | 1224 | 1225 | 1226 | 1227 | 1228 | 1229 | 1230 | 1231 | 1232 | 1233 | 1234 | 1235 | 1236 | 1237 | 1238 | 1239 | 1240 | 1241 | 1242 | 1243 | 1244 | 1245 | 1246 | 1247 | 1248 | 1249 | 1250 | 1251 | 1252 | 1253 | 1254 | 1255 | 1256 | 1257 | 1258 | 1259 | 1260 | 1261 | 1262 | 1263 | 1264 | 1265 | 1266 | 1267 | 1268 | 1269 | 1270 | 1271 | 1272 | 1273 | 1274 | 1275 | 1276 | 1277 | 1278 | 1279 | 1280 | 1281 | 1282 | 1283 | 1284 | 1285 | 1286 | 1287 | 1288 | 1289 | 1290 | 1291 | 1292 | 1293 | 1294 | 1295 | 1296 | 1297 | 1298 | 1299 | 1300 | 1301 | 1302 | 1303 | 1304 | 1305 | 1306 | 1307 | 1308 | 1309 | 1310 | 1311 | 1312 | 1313 | 1314 | 1315 | 1316 | 1317 | 1318 | 1319 | 1320 | 1321 | 1322 | 1323 | 1324 | 1325 | 1326 | 1327 | 1328 | 1329 | 1330 | 1331 | 1332 | 1333 | 1334 | 1335 | 1336 | 1337 | 1338 | 1339 | 1340 | 1341 | 1342 | 1343 | 1344 | 1345 | 1346 | 1347 | 1348 | 1349 | 1350 | 1351 | 1352 | 1353 | 1354 | 1355 | 1356 | 1357 | 1358 | 1359 | 1360 | 1361 | 1362 | 1363 | 1364 | 1365 | 1366 | 1367 | 1368 | 1369 | 1370 | 1371 | 1372 | 1373 | 1374 | 1375 | 1376 | 1377 | 1378 | 1379 | 1380 | 1381 | 1382 | 1383 | 1384 | 1385 | 1386 | 1387 | 1388 | 1389 | 1390 | 1391 | 1392 | 1393 | 1394 | 1395 | 1396 | 1397 | 1398 | 1399 | 1400 | 1401 | 1402 | 1403 | 1404 | 1405 | 1406 | 1407 | 1408 | 1409 | 1410 | 1411 | 1412 | 1413 | 1414 | 1415 | 1416 | 1417 | 1418 | 1419 | 1420 | 1421 | 1422 | 1423 | 1424 | 1425 | 1426 | 1427 | 1428 | 1429 | 1430 | 1431 | 1432 | 1433 | 1434 | 1435 | 1436 | 1437 | 1438 | 1439 | 1440 | 1441 | 1442 | 1443 | 1444 | 1445 | 1446 | 1447 | 1448 | 1449 | 1450 | 1451 | 1452 | 1453 | 1454 | 1455 | 1456 | 1457 | 1458 | 1459 | 1460 | 1461 | 1462 | 1463 | 1464 | 1465 | 1466 | 1467 | 1468 | 1469 | 1470 | 1471 | 1472 | 1473 | 1474 | 1475 | 1476 | 1477 | 1478 | 1479 | 1480 | 1481 | 1482 | 1483 | 1484 | 1485 | 148 |
|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| 1- STATE REGISTRAR | | | | STATE OF MARYLAND 8 6 0 1 1 2 2 | | | |
|---|--|--|--|---|--|---|--|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | CERTIFICATE OF DEATH | | | |
| 1- DECEASED NAME | | | | 2a DATE OF DEATH | | | |
| FIRST MIDDLE LAST | | | | MONTH DAY YEAR | | | |
| Mary Lucille Harris | | | | January 11, 1986 | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE | |
| Female | | Black | | MONTH DAY YEAR | | YRS | |
| | | | | 5 30 1910 | | 75 | |
| 7a BIRTHPLACE | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED | | 9 BALTIMORE CITY OR COUNTY OF DEATH | |
| (STATE OR FOREIGN COUNTRY) | | | | (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | MD. | |
| Va. | | U.S.A. | | WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Baltimore City | |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | 12a USUAL OCCUPATION | | 12b KIND OF BUSINESS OR INDUSTRY | |
| (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | |
| Baltimore | | Maryland General Hospital | | Housewife | | Home | |
| 13a STATE | | | | 13b COUNTY | | | |
| Md. | | | | | | | |
| 13c CITY OR TOWN | | | | 13d INSIDE CITY LIMITS? | | | |
| Balto | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14 FATHER'S NAME | | | | 15 MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | |
| Joseph Rawlings | | | | Mary Bailey | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT ADDRESS | |
| (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | | | | |
| No | | | | 213-26-2138 | | Mrs Carolyn Parham 1630 Moreland Ave | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) Sepsis | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (b) | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| Adult onset diabetes mellitus, hypertension, cirrhosis | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a INJURY OCCURRED | | 21b PLACE OF INJURY | | 21c LOCATION | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | [AT HOME STREET FACTORY, OFFICE, FARM, ETC.] | | CITY OR TOWN COUNTY STATE | | | |
| 21d INJURY OCCURRED | | 21e PLACE OF INJURY | | 21f LOCATION | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | [AT HOME STREET FACTORY, OFFICE, FARM, ETC.] | | CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 16, 1985, to January 11, 1986, that (I) (we) last saw the deceased on January 11, 1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (I) (we) did not view the body after death. | | | | | | | |
| 22b SIGNATURE | | | | DEGREE | | 22c DATE SIGNED | |
| | | | | MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e ADDRESS | | | |
| Johnathan Kushner, M.D. | | | | c/o Maryland General Hospital | | | |
| 23a BURIAL, CREMATION, REMOVAL | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION | |
| (TYPE OR PRINT) | | | | | | CITY OR TOWN COUNTY STATE | |
| Burial | | 1/16/86 | | King Mem A. | | Balto Md. | |
| 24 FUNERAL DIRECTOR | | | | 25a DATE REC'D BY REGISTRAR | | | |
| NAME ADDRESS | | | | 25b REGISTRAR'S SIGNATURE | | | |
| Jas. A. Morton & Sons 1701 Laurens | | | | JAN 16 1986 | | | |

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|------------------|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) Napoleon Harris Sr. | | | 2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 1 27 86 | | 2b. HOUR 8:25 AM |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 9 1909 | 6. AGE (IN YEARS) LAST BIRTHDAY 76 YRS. | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | 8. IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Danville, VA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IE NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK) (NOT NECESSARILY WORKING IN LIFE) Retired | |
| 13a. STATE Md | | 13b. COUNTY AA Co | | 13c. CITY OR TOWN Annapolis | |
| 14. FATHER'S NAME Thomas | | 15. MOTHER'S MAIDEN NAME Sally Harris | | 16. ADDRESS 204 Bowie Ave. Annapolis, Md | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF NOT, GIVE WAR OR DATES) ARMY 224-10-4937 | | 17. INFORMANT Sadie Phelps Harris | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE Dennis F. Smyth, M.D. | | TITLE (SPECIFY) M.D. Assistant | | MEDICAL EXAMINER DATE SIGNED 1-27-86 | |
| EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. | | ADDRESS 111 Penn St., Balto., MD 21201 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Type) | | 23b. DATE 1/30/86 | | 23c. NAME OF CEMETERY OR CREMATORY Lakewood | |
| 23d. LOCATION CITY OR TOWN Dundeeville | | COUNTY AA | | STATE Md | |
| 24. FUNERAL DIRECTOR Wm Reese & Sons | | ADDRESS 521 West St | | 25a. DATE REC'D. BY REGISTRAR JAN 28 1986 | |
| 25b. REGISTRAR'S SIGNATURE | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1 AND 2 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM P-1. RETAIN PAGE 5 FOR YOUR FILES. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM P-1. RETAIN PAGE 5 FOR YOUR FILES. PAGE 6 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01124

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|---|--|---|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) ROBERT S. HARRIS | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 18 86 | | | 2b. HOUR 830 M P. | | | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 7 29 1923 | | 6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Welder | | 12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel | | |
| 13a. STATE Maryland | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Dundalk | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 810 Mildred Avenue 21222 | |
| 14a. FATHER'S NAME FIRST MIDDLE LAST Leroy Harris | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Sneade | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 229-16-5099 | | 17. INFORMANT ADDRESS Lenora R. Harris Same as 13e | | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC ADENOCARCINOMA DUE TO, OR AS A CONSEQUENCE OF POORLY DIFFERENT AKED PROBABLY COLON Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from January 1, 19 86 to JANUARY 18 19 86 , that (I) (we) lost saw the deceased alive on JANUARY 18 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE John R Bartholomew | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 1/14/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN R BARTHOLOMEW | | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1/22/1986 | | 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. | | | | | ADDRESS 7922 Wise Avenue Dundalk, Maryland 21222 | | | 25a. DATE REC'D. BY REGISTRAR JAN 27 1986 | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

010110

FOR
1- STATE
REGISTRARSTATE OF MARYLAND 8 6
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01125

REG. NO.

| | | | | | | | | | | | | | | | | | |
|---|--|--|---|---|---|---|---|---|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) SARAH ELIZABETH HARRIS | | | 2a. DATE OF DEATH MONTH DAY YEAR 1-6-86 | | 2b. HOUR M | | | | | | | | | | | | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 12 31 1929 | | 6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN. | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Roanoke, Va. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH City MD. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Balto | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Staff Builder | | 12b. KIND OF BUSINESS OR INDUSTRY Retail | | | | | | | | | | |
| 13a. STATE Md. | | | | 13b. COUNTY | | 13c. CITY OR TOWN Balto | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 3511 Windsor Mill 21216 | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Allen | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pauline Clayton | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216 28 3898 | | | | | | | |
| 17. INFORMANT George W. Harris | | | | ADDRESS 3511 Windsor Mill | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CALCIFIC ARTERIOSCLEROSIS</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>HEART ATTACK</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22. I certify that (I) (this hospital) attended the deceased from <u>Nov</u> , 19 <u>82</u> , to <u>July</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>1-1-86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE <u>A. P. Sidhu</u> | | DEGREE | | 22c. DATE SIGNED 1-8-86 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ajai Sidhu M.D. | | 22e. ADDRESS 1009 Ingleside Ave Balto, Md 21228 | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/9/86 | | 23c. NAME OF CEMETERY OR CREMATORY King Mem. Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md. | | 24. FUNERAL DIRECTOR NAME ADDRESS James A. Morton & Sons 1701 Laurens | | 25a. DATE REC'D. BY REGISTRAR JAN 8 1986 | | 25b. REGISTRAR'S SIGNATURE <u>James A. Morton</u> | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page from the certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2511-08

C 1610

ADDITIONAL

NOTES



2511-08

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and signed in the presence of the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages are numbered and within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical record must be attached.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Clayton Edward Hart</u> | | | | 2a. DATE OF DEATH MONTH DAY YEAR <u>1 25 86</u> | | | |
| 3. SEX <u>Male</u> | | 4. RACE <u>White</u> | | 5. DATE OF BIRTH MONTH DAY YEAR <u>3 31 14</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>71</u> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>New Jersey</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD. | |
| 10. CITY OR TOWN OF DEATH <u>Balto. City</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>5105 Ardmore Way 21206</u> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Welder</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>Anchor Fence</u> | |
| 13a. STATE <u>Md.</u> | | 13b. COUNTY <u>Baltimore</u> | | 13c. CITY OR TOWN <u>Baltimore</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <u>Leroy Hart</u> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Mable Nicholson</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u> | | 16b. SOCIAL SECURITY NO. <u>212-03-1708</u> | | 17. INFORMANT ADDRESS <u>Grace L. Hart 5105 Ardmore Way 21206</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic congestive Card myopathy (heart failure)</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>A.S.C.V.D.</u> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>10 years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Renal failure + Diabetes mellitus</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3</u> 19 <u>85</u> to <u>1/25</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>1/23</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Leo E. Gresser M.D.</u> | | | | DEGREE <u>M.D.</u> | | 22c. DATE SIGNED <u>1/27/86</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Leo E. Gresser M.D. 433-6300</u> | | | | 22e. ADDRESS <u>6112 York Rd. Towson, Md. 21212</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>1-29-86</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore, Maryland</u> | |
| 24. FUNERAL DIRECTOR NAME <u>Lassahn Funeral Home</u> | | | | 25a. DATE REC'D. BY REGISTRAR <u>JAN 30 1986</u> | | 25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u> | |

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|---|--|---|--|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LAVINA L. HART | | | 2a. DATE OF DEATH MONTH DAY YEAR January 18, 1986 | | 2b. HOUR 9:00A M | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR February 16, 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 74 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5313 Brabant Road | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY Hospital | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Cyrus Hough | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lavina Raub | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES GIVE WAR OR DATES) 216-20-2078 | | 17. INFORMANT ADDRESS 8870 Carrollton Avenue Geraldine Fisher Savage, MD. 20763 | | | | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOVASCULAR ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

HYPERTENSION

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | | | | | |
|---|--|--------|--|--|--|------------------------------------|--|
| 22b. SIGNATURE Walter J. Alt, M.D. | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/20/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER J. ALT, M.D. | | | | 22e. ADDRESS 301 Marybell Road, Irvington, MD. | | | |

| | | | | | | | |
|---|--|-----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial | | 23b. DATE 1/22/86 | | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD. | |
| 24. FUNERAL DIRECTOR LeRoy M. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, MD. 21228 | | | | 25a. DATE REC'D. BY REGISTRAR JAN 21 1986 | | 25b. REGISTRAR'S SIGNATURE | |

053012

Handwritten notes and stamps, including a circular stamp with a rectangular box inside, and various illegible markings.

0.1131

Female White April 7, 1971 51

Mr. 121

Horowitz

Mr. 2710 Parkway Avenue 1971

Richard L. Group 1. 1971

no 1971-72 Dr. William L. Dr. L. 2000

1100



1971-72 Dr. L. 2000

Leonard J. Mack Inc. Baltimore, Maryland

021045

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | |
|---|---|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOAN A HARTMAN | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 16, 1985 1986 | | 2b. HOUR P 4:50 M |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 9-4-1933 | 6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS. | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) CO. Md. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | | | 13b. COUNTY Balto. | 13c. CITY OR TOWN Balto. | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph F. Hoenig | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eleanor Peters | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-30-9834 | 17. INFORMANT ADDRESS Deborah Kinsey, 3814 Ednor Rd. 21218 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>LUNG CANCER</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 7 year |
| PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JAN 5</u> 19 <u>86</u> to <u>JAN 16</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>JAN 16</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Alexander Hantel MD</u> | DEGREE | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED 1/16/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALEXANDER HANTEL | 22e. ADDRESS 600 N. WOLFE ST BALT MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 1-20-86 | 23c. NAME OF CEMETERY OR CREMATORY Parkwood | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md. | | |
| 24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc., 5305 Harford Rd. | | 25a. DATE REC'D. BY REGISTRAR JAN 17 1986 | | 25b. REGISTRAR'S SIGNATURE <u>Julia Anderson</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, a medical examiner should be called to examine the body.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01130

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|--|--|--|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) CHARLES ROBERT HARTNETT, SR. | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 6 86 | | 2b. HOUR 10¹⁰ P.M. | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 10 19 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Police Officer | | 12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Henry Hartnett | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Emma Glass | | 16. STREET ADDRESS / ZIP CODE 807 S. Ellwood Avenue 21224 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. WW II 216-05-8682 | | 17. INFORMANT ADDRESS: 3102 Yorkway Charles R. Hartnett, Jr., Balto., MD. 21222 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPOTENSION | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 16 H |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | (b) CARDIAC ARREST 16 H |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | (c) DUE TO, OR AS A CONSEQUENCE OF |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): ATRIAL FIBRILLATION | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/6 19 86 , to 1/6 19 86 , that (I) (we) lost saw the deceased alive on 1/6 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE M Earl Heard Jr | | DEGREE MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/6/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. HEARD | | 22e. ADDRESS 4940 EASTERN AVE. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/10/1986 | | 23c. NAME OF CEMETERY OR CREMATORY Cokesbury | | 23d. LOCATION CITY OR TOWN COUNTY STATE Abingdon Harford Maryland |
| 24. FUNERAL DIRECTOR NAME ADDRESS Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 | | | | 25a. DATE REC'D. BY REGISTRAR JAN 10 1986 | | |
| | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

682 JOURNAL OF DOCUMENTATION

021017

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|---|---|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <u>Henretta Hatchett</u> | | | 2a. DATE OF DEATH MONTH <u>1</u> DAY <u>13</u> YEAR <u>86</u> | | | 2b. HOUR <u>2:43</u> <u>A</u> M | | | | | |
| 3. SEX <u>Female</u> | | 4. RACE <u>col</u> | | 5. DATE OF BIRTH MONTH <u>4</u> DAY <u>24</u> YEAR <u>1897</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>88</u> YRS | | IF UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u> | | IF UNDER 24 HRS HOURS <u> </u> MIN. <u> </u> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Virginia</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>BALTIMORE City</u> MD | | | | | |
| 10. CITY OR TOWN OF DEATH <u>BALTIMORE</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>North Charles Gen. Hosp</u> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Homemaker</u> | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13b. STREET ADDRESS / ZIP CODE <u>1701 Eutaw Place Apt 1025</u> <u>21217</u> | | | | | | | |
| 14. FATHER'S NAME FIRST <u>OSCAR</u> MIDDLE <u> </u> LAST <u>Smith</u> | | | | 15. MOTHER'S MAIDEN NAME FIRST <u>Mary</u> MIDDLE <u>S.</u> LAST <u>Hudson</u> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u> | | | | 16b. SOCIAL SECURITY NO. <u>217-01-0428</u> | | 17. INFORMANT ADDRESS <u>Mrs. Bernice White 3709 Calhoun Ave</u> <u>21215</u> | | | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>atherosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <u>Azotemia</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u> </u> P.M. <u> </u> <u>19</u> | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/27</u> 19 <u>86</u> , to <u>1/13</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>1/13</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>[Signature]</u> | | | | DEGREE <u>MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED <u>1/13/86</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>K. DESAI</u> | | | | 22e. ADDRESS <u>2724 NORTH CHAS ST.</u> <u>BALTIMORE MD 21218</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | | 23b. DATE <u>1-16-86</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Arbutus Memorial</u> | | | 23d. LOCATION CITY OR TOWN <u>BALTO.</u> COUNTY <u>Co.</u> STATE <u>Md</u> | | | |
| 24. FUNERAL DIRECTOR NAME <u>Joseph L. Russ</u> ADDRESS <u>2222 W. North Ave.</u> | | | | | | 25a. DATE REC'D. BY REGISTRAR <u>JAN 17 1986</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |

MEDICAL CERTIFICATION

29

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner is the notified of office.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place in the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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2010 COLLECTOR'S

WINTER 2010



020005

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

 DHMH - 16 60M 7/84
 (VRA 15, 4)

 STATE OF MARYLAND 8 6
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

 1. FOR
 STATE
 REGISTRAR

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|---|--|---|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) <i>Mary</i> FIRST MIDDLE LAST <i>Hawkins</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>1-11-86</i> | | 2b. HOUR <i>4 p</i> M | |
| 3. SEX <i>FEMALE</i> | | 4. RACE <i>BLACK</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>12 15 92</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>93</i> YRS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTIMORE</i> MD. |
| 10. CITY OR TOWN OF DEATH <i>City</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>LUTHERAN HOSPITAL</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <i>Retired</i> | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <i>Maryland</i> 13b. COUNTY <i>Baltimore</i> | | | 13c. CITY OR TOWN <i>Baltimore</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Samuel EBIZ</i> | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>NANCY HOLLAND</i> | | | 13e. STREET ADDRESS / ZIP CODE <i>904 N. DuKeland St. 21216</i> |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. <i>219-30-8098</i> | | 17. INFORMANT ADDRESS <i>Chart</i> | | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Septicemia from decubitus ulcer</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Dehydration</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>8/10</i> 19 <i>86</i> to <i>1/11</i> 19 <i>88</i> , that (I) (we) lost saw the deceased alive on <i>1/11</i> 19 <i>88</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>[Signature]</i> | | DEGREE <i>MD</i> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <i>1/11/88</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Moges Gebremanan</i> | | 22e. ADDRESS | | | | | |

| | | | | | | | |
|---|--|--------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>1-17-86</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>KING MEM. PARK</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>BALTIMORE MARYLAND</i> | |
| 24. FUNERAL DIRECTOR <i>E.L. Phillips</i> | | | | 25a. DATE REC'D. BY REGISTRAR <i>JAN 16 1986</i> | | 25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | |



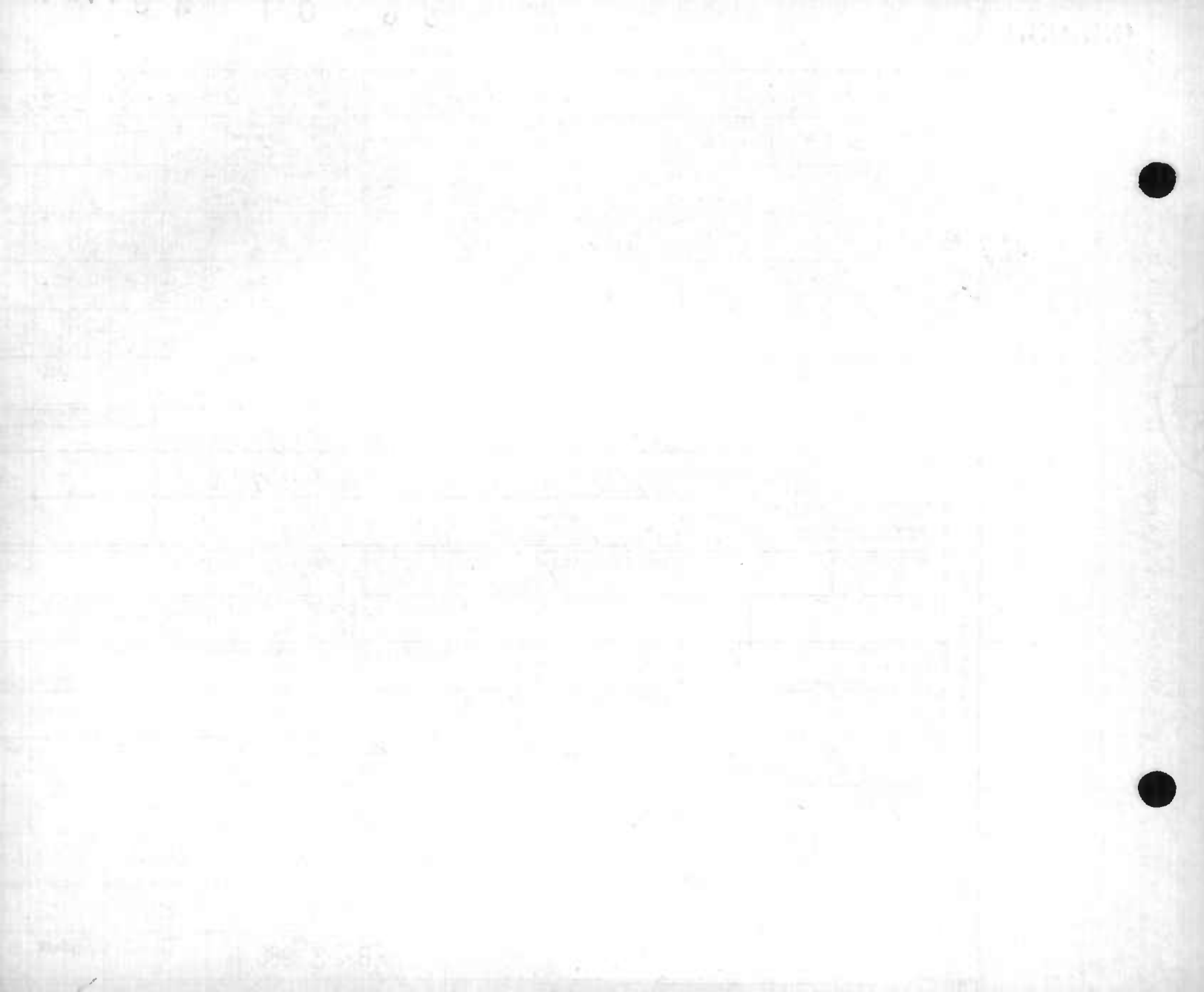
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) OPHELIA | | | | 2a. DATE OF DEATH MONTH 01 DAY 28 YEAR 86 | | | |
| 1. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH 2 DAY 27 YEAR 1986 | | 6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) S. Carolina | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, City | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Granada nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Notary Public | | 12b. KIND OF BUSINESS OR INDUSTRY Notary | |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST Isiah MIDDLE Knuckles LAST Knuckles | | 15. MOTHER'S MAIDEN NAME FIRST Elizabeth MIDDLE Littlejohn LAST Littlejohn | | 16. ADDRESS 3329 Mondawmin Ave. Baltimore, Md. 21216 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 215-03-9777 | | 17. INFORMANT ADDRESS 3329 Mondawmin Ave. Baltimore, Md. 21216 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Arterio sclerotic Cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) congestive Heart failure PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Cardiac arrhythmia - atrial tachycardia | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov , 19 86 , to Jan , 19 86 , that (I) (we) last saw the deceased alive on 28 Jan , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Franklin J. Addison, M.D. DEGREE MD | | | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Franklin J. Addison, M.D. | |
| 22e. ADDRESS 924 W. North Ave | | | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | |
| 23b. DATE 2/3/1986 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore, National Cemetery | | 23d. LOCATION CITY OR TOWN Baltimore COUNTY Baltimore STATE Md. | | 24. FUNERAL DIRECTOR Mutter & Sons Funeral Home, Inc. 2501 Gwynns Falls Pkwy. Baltimore, Md. 21216 | |
| 25a. DATE REC'D. BY REGISTRAR FEB 03 1986 | | | | 25b. REGISTRAR'S SIGNATURE Shirley A. Davidson | | | |



023125

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 01134

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | |
|--|---|---|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) ROBERT F HAWKINS, Sr. | | | 2a. DATE OF DEATH MONTH DAY YEAR 01 16 86 | | 2b. HOUR MIN. 0830 PM | |
| 3. SEX M | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 5 4 20 | | 6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS. | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0 | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOME FACILITY, GIVE STREET ADDRESS) PROVIDENT HOSPITAL | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Government | | 12b. KIND OF BUSINESS OR INDUSTRY Post Office | | 13. STREET ADDRESS / ZIP CODE 2503 Violet Ave 21215 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Robert F. Hawkins | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora E. Frost | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. 214-12-8394 | | 17. INFORMANT ADDRESS Evelyn Hawkins 5421 Wabash Ave | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a _____ | | | | | | |
| 19a. DATE OF OPERATION | | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE J. Martin MD | | 22c. DEGREE MD | | 22d. DATE SIGNED 1/16/86 | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) Sacker L. Martin MD | | 22f. ADDRESS Provident Hospital; Balt MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/20/86 | | 23c. NAME OF CEMETERY OR CREMATORY Md. Vet Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville, Md. |
| 24. FUNERAL DIRECTOR NAME Wm C Mch F/ H West | | | | 25a. DATE REC'D. BY REGISTRAR JAN 21 1986 | | 25b. REGISTRAR'S SIGNATURE [Signature] |

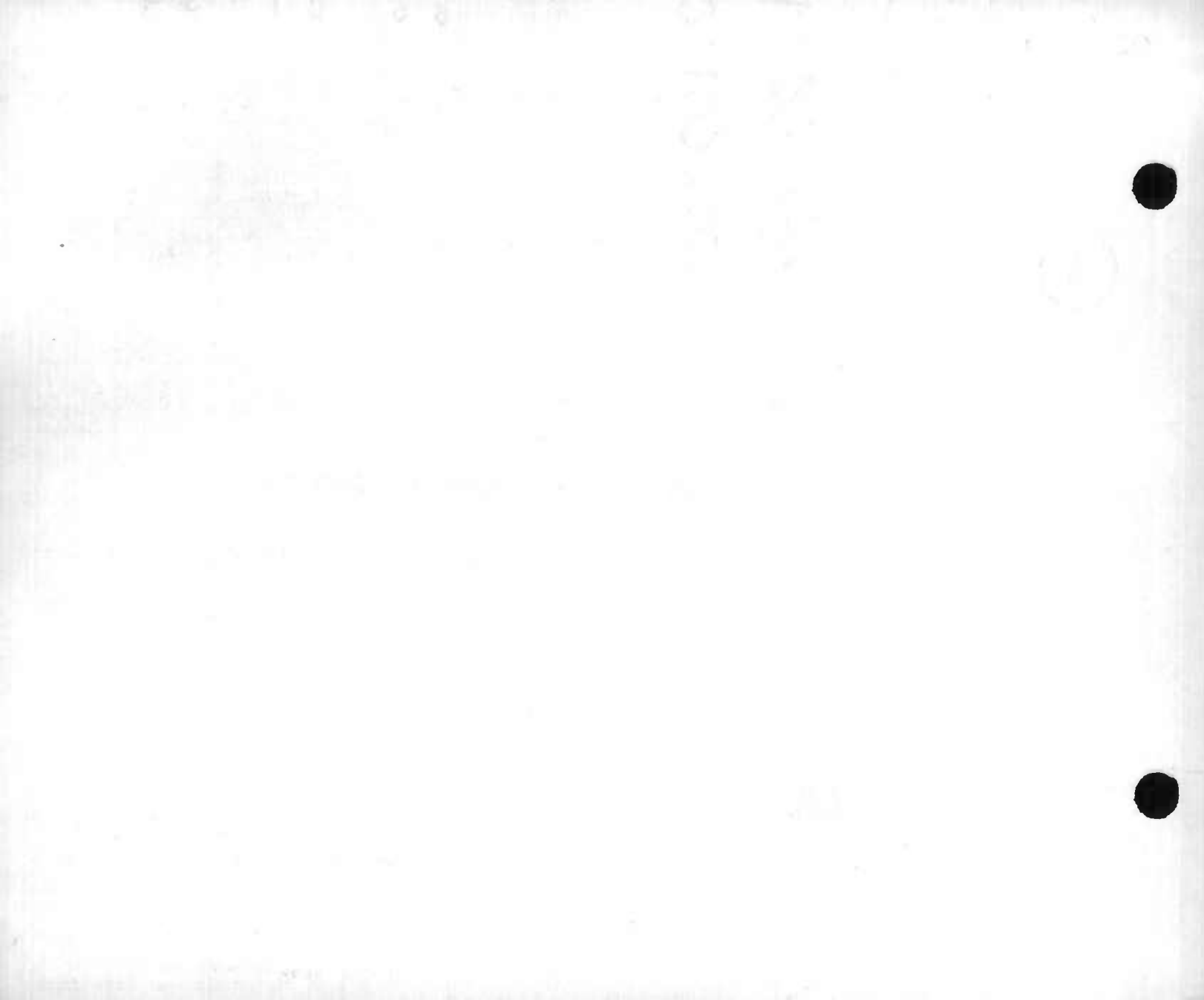
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and send them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



010018

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | |
|---|--|---|---|---|---|--|---------------------------------------|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILDA M. HAY | | | 2a. DATE OF DEATH MONTH DAY YEAR 01 07 86 | | 2b. HOUR 5:20 A.M. | | | | | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 9 7 14 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY OF MARYLAND HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY --- | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 1326 W. Lombard Street 21223 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frank Griffith | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hazel Unknown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 268-20-0648 | | | 17. INFORMANT ADDRESS Joseph J. Burford 331 S. Gilmore St. 21223 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) RESPIRATORY INSUFFICIENCY DUE TO, OR AS A CONSEQUENCE OF (c) --- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/23 19 85 to 1/7 19 86 , that (I) (we) lost saw the deceased alive on 1/7 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE P. Becker MD | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 1/7/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) PATRICE BECKER MD | | | | | | 22e. ADDRESS UNIV MARYLAND HOSPITAL 22 SCREENEAST BALTIMORE | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1/10/86 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn Pk. A.A. Maryland | | | | |
| 24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave. | | | | | | 24b. ADDRESS 21229 | | 25a. DATE REG'D. BY REGISTRAR JAN 8 1986 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | |

MEDICAL CERTIFICATION

29

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called for advice.

BP

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NEWARK CITY

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UNIVERSITY OF NEWARK HOSPITAL

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UNIVERSITY OF NEWARK HOSPITAL

UNIVERSITY OF NEWARK HOSPITAL

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UNIVERSITY OF NEWARK HOSPITAL

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STATE OF MARYLAND 6

01138

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1 DECEASED NAME (TYPE OR PRINT) Myrtle E. Hayes | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1-21-1986 | | 2b. HOUR 9am. | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 5-1-1898 | | 6. AGE (IN YEARS LAST BIRTHDAY) 87 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, city | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY OR COUNTY, GIVE FULL ADDRESS) Wesley Home Inc. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ? | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | 13b. COUNTY Baltimore | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13d. HOME ADDRESS 2211 W. Rogers Ave. 21209 | |
| 14. FATHER'S NAME MIDDLE Howard Fowler | | | | 15. MOTHER'S MAIDEN NAME MIDDLE Annie Wahl | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, IF OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-16-8527 215-46-6013 | | 17. INFORMANT Alexandria, Va. 22314 Wesley Home Inc. 2211 W. Rogers Ave. Mrs. JoDee Gonzalez 21101 Powhatan St. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years Years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in item 18, Part 1 or Part 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (i) (this hospital) attended the deceased from FEB 19 79 to JAN 21 1986 , that (ii) (we) last saw the deceased alive on 12-12 19 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (i) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Robert E. Roby Jr. | | | | DEGREE M.D. | | 22c. DATE SIGNED 1/21/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT E. ROBY JR. | | | | 22e. ADDRESS 8817 Belair Rd 21236 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Jan. 23, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY Balto. Nat'l. Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md. | |
| 24. FUNERAL DIRECTOR (NAME) C. Truman Schwartz | | | | 3512 Frederick Ave. ADDRESS # 21229 | | 25a. DATE REC'D. BY REGISTRAR FEB 03 1986 | |
| | | | | 25b. REGISTRAR'S SIGNATURE John Davidson-Randell | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP.

DHMH - 16 50M 1/B1
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

030007



SEP 03 1961

020250

STATE OF MARYLAND 8 6
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|--|--|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) BENNET RUCKER HAYS | | | 2a. DATE OF DEATH MONTH DAY YEAR JAN 14 1986 | | 2b. HOUR 3:25 PM | | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 05 22 | | 6. AGE (IN YEARS LAST BIRTHDAY) 63 | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | IF UNDER 72 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TENNESSEE | | 7b. COUNTRY OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY OF MARYLAND | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mech. Eng. | | 12b. KIND OF BUSINESS OR INDUSTRY Civil Serv. | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MARYLAND | | | | 13b. COUNTY AA Co. | | 13c. CITY OR TOWN Severn | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 8 BURNS CROSSING ROAD 21144 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOHN H HAYS | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSIE ROBINSON | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | | 16b. SOCIAL SECURITY NO. 410-38-5693 | | 17. INFORMANT (Mrs. Mary Hays | | | | ADDRESS Same as 13 Wife | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) BRAIN STEM HERNIATION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) CEREBRAL HEMISPHERE LESION STROKE. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 min 6 DAYS 24 DAYS | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) RENAL FAILURE | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2 JAN 1986 to 14 JAN 1986 , that (I) (we) lost saw the deceased alive on 14 JAN 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE [Signature] | | | | | | DEGREE | | 22c. DATE SIGNED 1/14/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANASTACIO DE CASTRO | | | | | | 22e. ADDRESS 22. S. GREENE ST BALDWIN UNIVERSITY OF MARYLAND HOSPITAL 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE Jan. 18, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn Mem. Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Nashville Tenn. | | | | |
| 24. FUNERAL DIRECTOR NAME Singleton Funeral Home | | | | | | ADDRESS Glen Burnie Md. | | 25a. DATE REC'D. BY REGISTRAR JAN 16 1986 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

2 PAH

037023

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|--|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) RICHARD R HEATH | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 29, 1986 | | 2b. HOUR 8:19PM |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 2 13 22 | 6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician | 12b. KIND OF BUSINESS OR INDUSTRY Johns Hopkins | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 9203 Smith Ave. Balto., Md. 21234 |
| 14. FATHER'S NAME FIRST MIDDLE LAST Wilmer Heath | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Young | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | (IF YES, GIVE WAR OR DATES) WW1 | 16b. SOCIAL SECURITY NO. 215-14-4365 | 17. INFORMANT ADDRESS Merle Heath 9203 Smith Avenue Balto. Md. 21234 | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac failure

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

(b) metastatic carcinoma

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

20 min

1 year

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

| | | | |
|---|--|--|---|
| 19a. DATE OF OPERATION 1/22/86 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED metastatic Gall bladder Ca | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY OFFICE FARM, ETC) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/19 1986 to 1/29 1986, that (I) (we) last saw the deceased alive on 1/29 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE Thomas Magnuson | DEGREE | 22c. DATE SIGNED 1/29/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas Magnuson | 22e. ADDRESS JOHNS HOPKINS HOSPITAL/601 NORTH WOLFE STREET | | |

| | | | |
|--|---------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 2-1-86 | 23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley M.G. | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland |
| 24. FUNERAL DIRECTOR NAME Lassahn Funeral Home | | 25a. DATE RECD. BY REGISTRAR FEB 04 1986 | 25b. REGISTRAR'S SIGNATURE Davidson |

030750

LIBERTY COTTON 20%

MADE IN U.S.A.



LIBERTY COTTON

016031

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND 8 6 0 1 1 3 9
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|--|--|---|---|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VIRGINIA Earl HEBBEL | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 10, 1986 | | | 2b. HOUR 10:05 PM | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR January 20, 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Greene Cnty, Va. | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 28 N. Potomac St. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk | | |
| 12b. KIND OF BUSINESS OR INDUSTRY Crown Cork & Seal | | | | | | | | |
| 13a. STATE Md. | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | | |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE 28 N. Potomac St. - 21224. | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Genus --- Morris | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bettie --- ?? | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 217-07-5404 | | 17. INFORMANT Baltimore, Md. 21224 William M. Hebbel - 28 N. Potomac St. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Adeno-CA of Colon DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mch | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11/10 19 85 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/10 , 19 85 , to 1/10 , 19 86 , that (I) (we) last saw the deceased alive on 11/10 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE T V PARRAW MD | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/11/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) T V PARRAW | | 22e. ADDRESS 4440 Eastern Ave Bult 21224 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/13/86 | | 23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem. - Baltimore, Maryland | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| 24. FUNERAL DIRECTOR John A. Moran, Inc. Funeral Home NAME ADDRESS 3000 E. Baltimore St.; Baltimore, Md. 21224 | | | | | | | | |

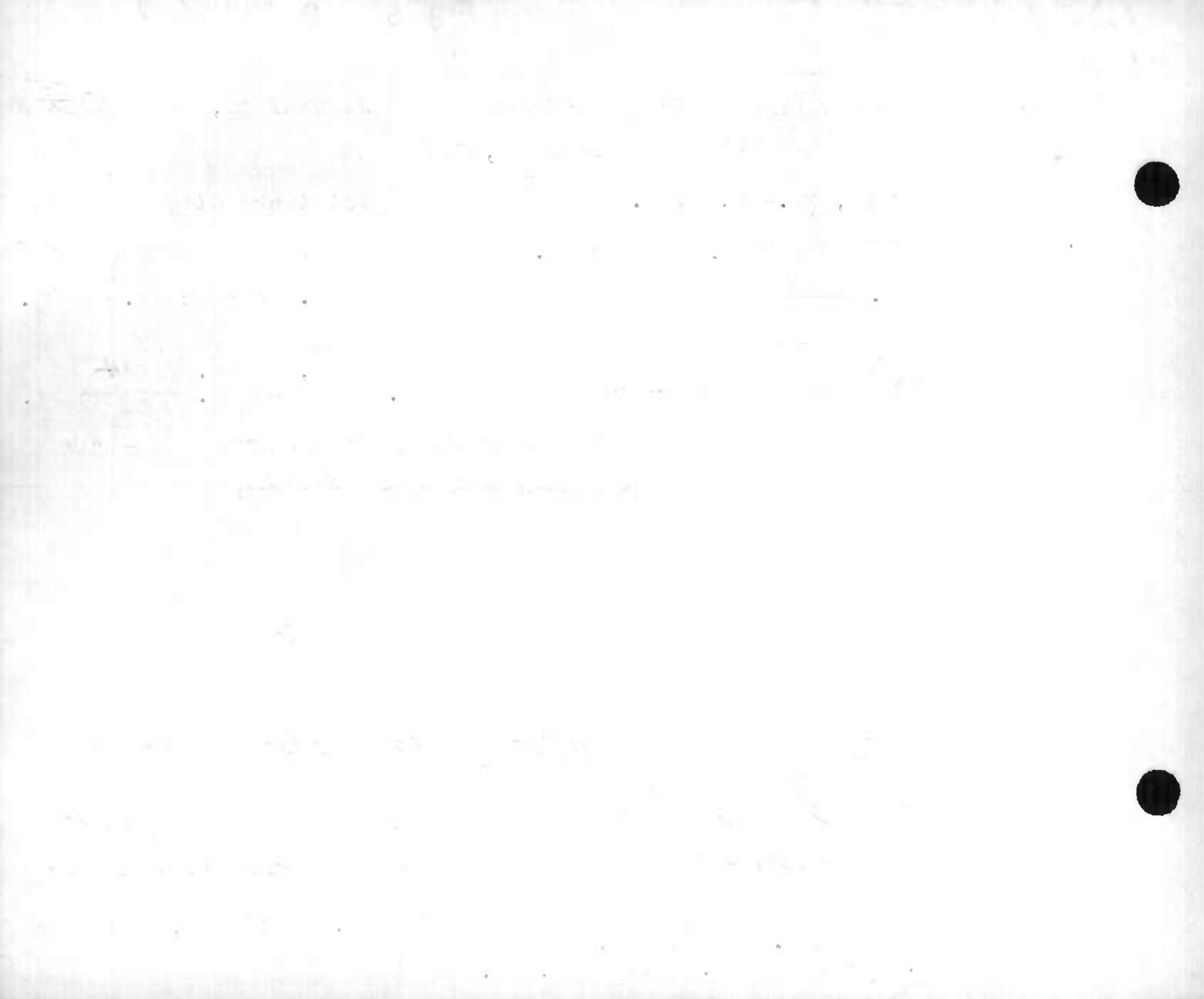
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be filed at once.

BP



009096

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRAVEL WITH PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

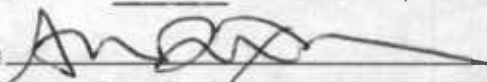

BP

DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|---|--|--|---|--|--|---|--|--|---|--|--|-----------------------------------|--|--|--|--|---|---------------------|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST AUBREY | | | MIDDLE WILLIAM | | | LAST HECKSTALL SR. | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR | | | 2b. HOUR | | | | | | | | | | | | | | |
| 3. SEX M | | | 4. RACE B | | | 5. DATE OF BIRTH MONTH DAY YEAR 7 24 29 | | | 6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 56 | | | IF UNDER 1 YR. MONTHS DAYS | | | IF UNDER 24 HRS. HOURS MIN | | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 4 19 86 | | | 2d. HOUR 5:13 AM | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA. | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 600 blk. N. Chester St. | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | |
| 13a. STATE MARYLAND | | | 13b. COUNTY | | | 13c. CITY OR TOWN BALTIMORE | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS 21205 807 N. PATTERSON PARK AVE. | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST SCOTT HECKSTALL | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN | | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | | | | 16b. SOCIAL SECURITY NO. 220-20-9759 | | | | | | 17. INFORMANT HILDA F. HECKSTALL 807 N. PATTERSON AVE. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Alcoholism</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> . (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 1a. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | 20. AUTOPSY? Head Only YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | | | DATE SIGNED 1-4-86 | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | | | | ADDRESS 111 Penn St., Balto., MD 21201 | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | | | 23b. DATE 1-8-86 | | | | | | 23c. NAME OF CEMETERY OR CREMATORY MOUNT ZION | | | | | | 23d. LOCATION CITY OR TOWN COUNTY LANSDOWNE MARYLAND | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME WM.C. MARCH F/H INC. | | | | | | | | | | | | ADDRESS 1101 E. NORTH AVE. | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 7 1986 | | 25b. REGISTRAR'S SIGNATURE  | | | | | | | | | |

RECEIVED

UNITED STATES DEPARTMENT OF AGRICULTURE

PLANT INDUSTRY DIVISION

1914

034013

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01141

FOR
1. STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|---|---|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) First: <u>Mary</u> Middle: <u>E.</u> Last: <u>Heil</u> | | | 2a. DATE OF DEATH MONTH: <u>1</u> DAY: <u>29</u> YEAR: <u>86</u> | | 2b. HOUR <u>8:20 A.M.</u> | | | | |
| 3. SEX <u>♀</u> | | 4. RACE <u>White</u> | | 5. DATE OF BIRTH MONTH: <u>12</u> DAY: <u>18</u> YEAR: <u>02</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>83</u> YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland U.S.A.</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD. | | | |
| 10. CITY OR TOWN OF DEATH <u>Baltimore</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>S. Baltimore Gen. Hosp.</u> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Retired</u> | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE <u>Maryland</u> | | | 13b. COUNTY <u>Anne Arundel</u> | | 13c. CITY OR TOWN <u>Pasadena</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME First: <u>Julian</u> Middle: <u>Buraczynski</u> Last: <u>Eva</u> | | | 15. MOTHER'S MAIDEN NAME First: <u>Eva</u> Middle: <u>Adams</u> Last: <u>Adams</u> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) <u>NO -</u> | | | 16b. SOCIAL SECURITY NO. <u>21705417</u> | |
| 17. INFORMANT <u>Hospital chart</u> | | | 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>C9. of breast colon, & ureter, & uterus</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/27/86</u> 19 <u>86</u> to <u>11/29/86</u> 19 <u>86</u> that (I) (we) last saw the deceased alive on <u>11/29/86</u> 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Harry R. Burman, M.D.</u> | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <u>11/29/86</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Harry R. Burman</u> | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (IF) | | 23b. DATE <u>2/1/86</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem.</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Dr. Pitches Highway</u> | | | |
| 24. FUNERAL DIRECTOR NAME <u>Charles L. Stevens</u> | | | | 25a. DATE REC'D. BY REGISTRAR <u>1501 E. Fort St.</u> | | 25b. REGISTRAR'S SIGNATURE <u>Jane Davidson-Randall</u> | | | |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a necropsy performed.

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20% COTTON

100% COTTON

027019

STATE OF MARYLAND 8 6
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|---|--|-----------------------------|--|--|--|--|--|---|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) | | 2a DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b HOUR | |
| Elsie | | 1 | | 22 | | 86 | | 745 | | p.m. | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7 IF UNDER 1 YEAR | | 8 IF UNDER 24 HRS | |
| Female | | White | | Nov. 1, 1908 | | 77 | | MONTHS | | DAYS | |
| 9a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 9b CITIZEN OF WHAT COUNTRY? | | 10 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | 11a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 11b KIND OF BUSINESS OR INDUSTRY | |
| Maryland | | U.S.A. | | | | Baltimore City, | | Housewife | | | |
| 12a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | | 13e STREET ADDRESS / ZIP CODE | |
| Maryland | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 6200 Marglenn Ave. | | 21206 | |
| 14 FATHER'S NAME | | 15 MOTHER'S MAIDEN NAME | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT | | ADDRESS | |
| Charles | | Ella | | No | | 216-34-8587 | | Mr. John W. Helbing, Jr. | | Same as #13e | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | 19 IMMEDIATE CAUSE (a) | | 20 DUE TO, OR AS A CONSEQUENCE OF | | 21 (b) | | 22 DUE TO, OR AS A CONSEQUENCE OF | | 23 (c) | |
| Breast carcinoma with widespread metastases | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | 24a DATE OF OPERATION | | 24b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 24c AUTOPSY? | | 24d IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | 24e APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 25a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 25b TIME OF INJURY | | 25c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 25d PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 25e LOCATION | | 25f CITY OR TOWN | |
| | | P.M. | | | | | | | | | |
| 26a INJURY OCCURRED | | 26b PLACE OF INJURY | | 26c LOCATION | | 26d CITY OR TOWN | | 26e COUNTY | | 26f STATE | |
| | | | | | | | | | | | |
| 27a I certify that (I) (this hospital) attended the deceased from | | 27b SIGNATURE | | 27c DEGREE | | 27d ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 27e DATE SIGNED | | 27f APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 1/16 | | David R. Weber, MD | | MD | | | | 1/20/86 | | | |
| 28a PHYSICIAN'S NAME (TYPE OR PRINT) | | 28b ADDRESS | | 28c NAME OF CEMETERY OR CREMATORY | | 28d LOCATION | | 28e CITY OR TOWN | | 28f COUNTY | |
| David R. Weber, MD | | 65H 5601 Loch Raven Blvd. | | Parkwood | | Baltimore, Md. | | | | | |
| 29a BURIAL, CREMATION, REMOVAL (SPECIFY) | | 29b DATE | | 29c NAME OF CEMETERY OR CREMATORY | | 29d LOCATION | | 29e CITY OR TOWN | | 29f COUNTY | |
| Burial | | 1-24-86 | | Parkwood | | Baltimore, Md. | | | | | |
| 30a FUNERAL DIRECTOR | | 30b ADDRESS | | 30c DATE REC'D. BY REGISTRAR | | 30d REGISTRAR'S SIGNATURE | | 30e APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | 30f APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| Leonard J. Ruck, Inc. | | Baltimore, Md. | | JAN 23 1986 | | [Signature] | | | | | |

037010

20% COTTON FIBER



WELFARE
FUND

021025

1- FOR
STATE
REGISTRARSTATE OF MARYLAND 8 6
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|---|---|--|---|--|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) Kucille Henderson | | | 2a DATE OF DEATH MONTH DAY YEAR 1 12 86 | | | 2b HOUR 520 A M | | | |
| 3 SEX Female | | 4 RACE Black | | 5 DATE OF BIRTH MONTH DAY YEAR 3 1 19 | | 6 AGE (IN YEARS LAST BIRTHDAY) 66 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a BIRTHPLACE (COUNTRY) BALTO. Md | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD. | | | |
| 10 CITY OR TOWN OF DEATH Baltimore | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hospital | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Baltimore | | | | 13b COUNTY BALTO. | | 13c CITY OR TOWN BALTO. | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST UNKNOWN | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 218-76-5832 | | 17 INFORMANT ADDRESS Mrs Adwetta Taylor 2307 E/sinor Ave 21216 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF COLON DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.) | | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 12/1 19 85 to 1/12 19 86 that (I) (we) lost saw the deceased alive on 1/12 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE Ambachew Woreta DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | | 22c DATE SIGNED 1/12/86 | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) AMBACHEW WORETA | | | | | | 22e ADDRESS LUTHERAN HOSPITAL, BALTO | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b DATE 1-18-86 | | 23c NAME OF CEMETERY OR CREMATORY mt Zion Cem. | | 23d LOCATION CITY OR TOWN COUNTY STATE Handshune Co. Md | | |
| 24 FUNERAL DIRECTOR NAME Joseph L. Russ ADDRESS 2222 W North Ave | | | | | | 25a DATE REC'D. BY REGISTRAR JAN 17 1986 | | | |
| 25b REGISTRAR'S SIGNATURE | | | | | | | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be advised at once.

BP

021032

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DIRECT MAIL

311 NOTICE 3/03

020043

STATE OF MARYLAND

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1- FOR
STATE
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|---|---|--|---|---|
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIE E. HENDERSON | | | 2a DATE OF DEATH MONTH DAY YEAR 1 12 86 | | | 2b HOUR M | |
| 3 SEX F | | 4 RACE E | | 5. DATE OF BIRTH MONTH DAY YEAR 3 15 '12 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE, CITY MD. | |
| 10 CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH PLACE, GIVE STREET ADDRESS) 1208 E. 35th STREET | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND | | | | 13b COUNTY BALTIMORE | | 13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST JOHN MOSLEY | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LAURA HIGHTOWER | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-12-8908 | | 17 INFORMANT ADDRESS RAYMOND HENDERSON 1208 E. 35th STREET | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Concursive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Mental Intoxication</u> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>minutes</u> <u>minutes</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NO</u> | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>3-21</u> , 19 <u>85</u> , to <u>1-12</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>12-24-85</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE <u>Larry S. Perry</u> | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>1/14/86</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. LARRY S. PERRY MD | | | | 22e ADDRESS 107-109 E SARATOGA ST, SUITE 102, Balto. | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b DATE 1-18-86 | | 23c NAME OF CEMETERY OR CREMATORY DULANLEY VALLEY | | 23d LOCATION CITY OR TOWN COUNTY STATE BALTIMORE COUNTY MD. | |
| 24 FUNERAL DIRECTOR NAME WM. C. MARCH F/H INC. 1101 E. NORTH AVE. | | | | 25a DATE RECEIVED BY REGISTRAR JAN 16 1986 | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in the funeral director's office. It should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

009143

STATE OF MARYLAND 8 6 0 1 1 4 5
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

FOR
 1- STATE
 REGISTRAR

| | | | | | |
|--|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Vernon N. Henkel | | | 2a. DATE OF DEATH MONTH DAY YEAR 01 03 86 | | 2b. HOUR 12:55 AM |
| 3. SEX male | 4. RACE Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR 03 25 16 | 6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N/A | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Balt. Gen. Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) none | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Maryland | | 13b. CITY OR TOWN Baltimore | 13c. STREET ADDRESS 3743 St. Margaret St. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Henkel | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie England | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II | 17. INFORMANT ADDRESS Margaret L. Henkel same as #13 | | |
| 18. CAUSE OF DEATH Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Pulmonary Arrest | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary Congestion, Sepsis | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Renal failure, CHF & COPD | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: none | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that the this hospital attended the deceased from 12/16 , 19 85 , to 1/3/86 , 19 86 , that we I saw the deceased alive on 1/3 , 19 86 , and that in my our opinion death occurred on the date and hour and from the causes stated above, and that I did not view the body after death. | | | | | |
| 22b. SIGNATURE J. Griffin, MD | | DEGREE M.D. | | 22c. DATE SIGNED 1/3/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Griffin, MD | | 22e. ADDRESS 3001 S. Hanover St. South Baltimore Gen. Hosp. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-6-86 | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk. McCully F | | 23d. LOCATION (CITY OR TOWN) COUNTY Elkridge Howard MD |
| 24. FUNERAL DIRECTOR NAME McCully Funeral Home | | 24b. ADDRESS 237 E. Patapsco Ave. Balto., MD 21225 | | 25a. DATE REC'D. BY REGISTRAR JAN 1 1986 | |
| | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 3.

BP

030041

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

01146

 FOR
 STATE
 REGISTRAR

REG. NO.

| | | | | | |
|--|--|--|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) Ann Hennigan | | 2a DATE OF DEATH MONTH DAY YEAR 1 23 86 | | 2b HOUR 3⁰⁰ P.M. | |
| 3 SEX Female | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR April 3 1906 | |
| 6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa. | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | |
| 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD | | 10 CITY OR TOWN OF DEATH Baltimore | | | |
| 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress - O'Conner's Restaurant | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a STATE Md. | | 13b COUNTY Balto. | | 13c CITY OR TOWN Essex | |
| 14 FATHER'S NAME FIRST MIDDLE LAST John Hrehá | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Zardos | | | |
| 16 WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b SOCIAL SECURITY NO 213-20-3558 | | 17 INFORMANT Donald Hennigan 6 Bonnywick Dr. Harrisburg Pa. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac a-systole DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metabolic acidosis / possible sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Heart failure / Bowel gangrene APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10' 3d 2 1/2 weeks | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a AGE / HEART FAILURE / DIABETES | | | | | |
| 19a DATE OF OPERATION JAN 21 86 | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED ABDOMINAL SEPSIS/GANGLION | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) KU | |
| 21f LOCATION STREET CITY OR TOWN COUNTY STATE MD | | 22a I certify that (I) (this hospital) attended the deceased from JAN 21 19 86 to JAN 23 19 86 , that (I) (we) last saw the deceased alive on JAN 23 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b SIGNATURE David Nasrallah | | DEGREE MD | | 22c DATE SIGNED JAN 23/86 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) David Nasrallah | | 22e ADDRESS Union Memorial Hospital | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b DATE 1/25/86 | | 23c NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery | |
| 23d LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | 24 FUNERAL DIRECTOR NAME ADDRESS Connelly Funeral Home 300 Mace Ave. 21221 | | | |
| 25a DATE REC'D. BY REGISTRAR JAN 28 1986 | | 25b REGISTRAR'S SIGNATURE [Signature] | | | |

 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate from page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

021038

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01147

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|---|--|---|---|---|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <i>CAR FIELD</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>1 13 86</i> | | | 2b. HOUR <i>3 25</i> M | | | | |
| 3. SEX <i>MALE</i> | | 4. RACE <i>BLACK</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>5 7 03</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>82</i> YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTIMORE CITY, "</i> MD. | | | | |
| 10. CITY OR TOWN OF DEATH <i>BALTIMORE</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>912 EAST EAGER STREET</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>N/A</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i> | | | 13b. COUNTY <i>Baltimore</i> | | 13c. CITY OR TOWN <i>Baltimore</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE <i>912 E. Eager Street 21202</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Jarmiah Henry</i> | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Sophia Vaughn</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>YES</i> | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>271-10-8251</i> | | 17. INFORMANT ADDRESS <i>Nathaniel Henry 1926 Oakhill Avenue</i> | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *CARDIO PULMONARY ARREST*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) *CANCER of Lung*

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

10 MIN

1 year

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>Dorothy Snow</i> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <i>1/14/86</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dorothy Snow</i> | | | | 22e. ADDRESS <i>3900 Oak Raven Blvd Balt 21218</i> | | | |

| | | | | | | | |
|---|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i> | | 23b. DATE <i>1/20/86</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Baltimore Cemetery</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Md.</i> | |
| 24. FUNERAL DIRECTOR NAME ADDRESS <i>March Funeral Homes 1101 East North Avenue</i> | | | | 25. DATE REGD. BY DEPT. REGISTRAR <i>JAN 17 1986</i> | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

TO HOSPITAL'S ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove confidentially: Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be contacted at once.

021035

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01148

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Joyce A. Henson. | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 14 86 | | | 2b. HOUR 11:30 PM | |
| 3. SEX F. | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 7 13 48 | | 6. AGE (IN YEARS LAST BIRTHDAY) 37. YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANCIS SCOTT KEY MEDICAL CENTER | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNEMPLOYED | |
| 13a. STATE Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Herman A. Eppes | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mae E. Fowlkes | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-50-6159 | | 17. INFORMANT ADDRESS Herman Eppes 3930 Rexmere Road | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

Sev. days
3 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

Branchitis

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Joe Adams MD | | DEGREE MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | DR. DATE SIGNED 7/15/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joe Adams MD | | 22e. ADDRESS | | | | | |

| | | | | | | | |
|--|--|----------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 1/17/86 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co., Md. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS March Funeral Homes 1101 East North Avenue | | | | 25a. DATE REC'D. BY REGISTRAR JAN 17 1986 | | 25b. REGISTRAR'S SIGNATURE Lena Davidson-Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coloration papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

550130

20% COLL

022026

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) PAUL Eugene HENSON | | | 2a. DATE OF DEATH MONTH DAY YEAR JAN. 18, 1986 | | 2b. HOUR P M 2:05 |
| 3. SEX Male | 4. RACE Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 7, 1941 | | 6. AGE (IN YEARS LAST BIRTHDAY) 44 YRS | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist | 12b. KIND OF BUSINESS OR INDUSTRY Textile Ind. | |
| 13a. STATE N. C. | | | 13b. CITY OR TOWN Cleveland Mountain | 13c. STREET ADDRESS / ZIP CODE Route # 2 28086 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Jesse Henson | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Ledbetter | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None | 17. INFORMANT (wife) ADDRESS Patricia Allen Henson - Same as #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASYSTOLE | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 minutes |
| DUE TO, OR AS A CONSEQUENCE OF (b) CARDIOVASCULAR COLLAPSE AND SEPSIS | | | | | 18 days |
| DUE TO, OR AS A CONSEQUENCE OF (c) BONE MARROW TRANSPLANTATION | | | | | 27 days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b) Obesity | | | | | |
| 19a. DATE OF OPERATION 12/20 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Chronic Myelogenous Leukemia | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/18/85, 1985, to 1/18, 1986, that (I) (we) lost saw the deceased alive on 1/18, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Benton Hall MD. PH.D. | | DEGREE MD. PH.D. | | 22c. DATE SIGNED 1/18/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BENTON HALL | | 22e. ADDRESS 600 N. WOLFE ST. % JOHNS HOPKINS HOSPITAL, BALTO MD 21205 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 1-21-1986 | 23c. NAME OF CEMETERY OR CREMATORY Mountain Rest Cem. | 23d. LOCATION CITY OR TOWN STATE Cleveland Co. N.C. | | |
| 24. FUNERAL DIRECTOR NAME E. Barnes Fleming Funeral Service-Benson, Md. | | | 25a. DATE REC'D. BY REGISTRAR JAN 20 1986 | | |
| | | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Pond | | |

020056

NOV. 27 1967

AMERICAN

DATE

OFFICE OF THE ATTORNEY GENERAL

ADMINISTRATIVE

1968

ROUTE 2

STATE

CLERK

NAME

ADDRESS

(OFFICE)

1967

1968

1969



X

CLERK

1-11-1

1967

1968

1969

1970

023121

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01150

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) <i>Rosa E. Henson</i> | | | | 2a DATE OF DEATH MONTH DAY YEAR <i>1-18-86</i> | | | | 2b HOUR <i>12:05 AM</i> | |
| 3 SEX <i>FEMALE</i> | | 4 RACE <i>CAUCASIAN</i> | | 5 DATE OF BIRTH MONTH DAY YEAR <i>2 17 01</i> | | 6 AGE (IN YEARS LAST BIRTHDAY) <i>84</i> | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>West Va.</i> | | 7b CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD. | | | |
| 10 CITY OR TOWN OF DEATH <i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Deaton Hospital & Medical Center</i> | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i> | | 12b KIND OF BUSINESS OR INDUSTRY <i>Homemaker</i> | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <i>Virginia</i> | | 13b CITY OR TOWN <i>King George</i> | | 13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d STREET ADDRESS / ZIP CODE <i>PO Box 195 22485 99999</i> | | | |
| 14 FATHER'S NAME <i>John</i> | | 15 MOTHER'S MAIDEN NAME <i>Virginia SULFRIDGE</i> | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) <i>No</i> | | | | 16b SOCIAL SECURITY NO. <i>214-14 4715</i> | |
| 17 INFORMATION <i>Baltimore, Maryland</i> | | | | 18 ADDRESS <i>21229 Hazel Perdue 4141 Mountwood Road</i> | | | | | |
| 8 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Sepsis</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Decubitus Ulcer</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Diabetes</i> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>6 months</i> <i>years.</i> | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Organic dementia - Status Post Stroke</i> | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <i>12 23 19 85</i> to <i>1 17 19 86</i> , that (I) (we) last saw the deceased alive on <i>1 17 86</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (I) (we) did not view the body after death, so state.) | | | | | | | | | |
| 22b SIGNATURE <i>[Signature]</i> | | | | DEGREE <i>MD</i> | | | | 22c DATE SIGNED <i>1.18.86</i> | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>JOS W ZERLEY MD</i> | | | | 22e ADDRESS <i>611 S Charles Street Balto 21230</i> | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b DATE <i>1/22/86</i> | | 23c NAME OF CEMETERY OR CREMATORY <i>Glen Haven Park</i> | | 23d LOCATION CITY OR TOWN COUNTY STATE <i>Glen Burnie A A Maryland</i> | | | |
| 24 FUNERAL DIRECTOR NAME <i>Raymond C. Fink</i> | | | | 25a DATE REC'D. BY REGISTRAR <i>JAN 21 1986</i> | | 25b REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director. Page 3 should be detached for use as the burial permit. Then please remove stubs on pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

050121

RECEIVED
JAN 11 1966



RECEIVED
JAN 11 1966

Received from the Office of the Secretary of Defense
JAN 11 1966

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01151

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|---|---|---|--------------|--|-------------------|---|---|--|------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST william | MIDDLE L. | LAST Menson | 2a. DATE OF DEATH | | MONTH 1 | DAY 29 | YEAR 86 | 2b. HOUR 6:00 P.M. | |
| 3. SEX male | 4. RACE Black | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| | | MONTH 7 | | DAY 24 | | YEAR 45 | | YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, City MD | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FSK medical Center | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Press Dev. | | | 12b. KIND OF BUSINESS OR INDUSTRY Rubber Company | | | | |
| 13a. STATE Md | | 13b. COUNTY | | 13c. CITY OR TOWN Balt. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1305 Wilcox 21202 | | | |
| 14. FATHER'S NAME FIRST George | | MIDDLE | | LAST Henson JR. | | 15. MOTHER'S MAIDEN NAME FIRST Evelyn | | MIDDLE Chew | | LAST | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-44-1618 | | 17. INFORMANT Evelyn Henson | | ADDRESS Apt. 1305 | | 1102 DRUID HILL AVE. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) liver failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ETOH abuse DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-22, 1986, to 1-29, 1986, that (I) (we) last saw the deceased alive on 1-29, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE H. Touch | | DEGREE MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/29/86 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howard Touch | | MID | | 22e. ADDRESS FSK Medical Center | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 2-1-86 | | 23c. NAME OF CEMETERY OR CREMATORY Arbutus | | 23d. LOCATION CITY OR TOWN Arbutus | | COUNTY Md. | | STATE | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H Inc. | | | | ADDRESS 1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR JAN 30 1986 | | 25b. REGISTRAR'S SIGNATURE Sha. Davidson-Ross | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1954

JAN 26 1954

020333

Items 18-22a 2/21/86 mth F#612

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

0 1 1 5 2

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|---------|---|-------------------|--|------------------|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | Cynthia Jean Heppding | | 2a. DATE KNOWN OF DEATH | | 1 9 1986 | | 2b. HOUR | | 7:14A | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD | | 1 9 1986 | | 7:14A | |
| Female | White | 11 6 58 | 27 YRS. | | | 2c. DATE PRONOUNCED DEAD | | 1 9 1986 | | 7:14A | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | | U.S.A. | | | | Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | 3501 Horton Avenue | | | | Waitress | | Restaurant | | | |
| 13a. RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| Maryland | | Baltimore | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1504 Olmstead Street 21226 | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| Charles W. Heppding | | Jean B. Zebron | | No | | 219-70-1131 | | Jean B. Heppding | | Same as 13e | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Narcotism</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) <u>the underlying cause lost.</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | | | | | |
| 22a. I certify that took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | |
| <i>Dennis F. Smyth, M.D.</i> | | | | D. Assistant MEDICAL EXAMINER | | | | 1/9/86 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | |
| Dennis F. Smyth, M.D. | | | | 111 Penn St. Balto.MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN | | COUNTY | | STATE | |
| Burial | | 1/17/86 | | Holy Cross Cemetery | | Balto | | A.A. | | Md | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| George J. Gonce 4001 Ritchie Hgwy Balto Md | | | | | | JAN 16 1986 | | <i>[Signature]</i> | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25MBP 19
DHMH - 17
(VR A15 ME (5))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 9, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. GIVE PAGES 1, 9, AND 3 TO THE FUNERAL DIRECTOR. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

21



[Handwritten signature]

016094

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01153

FOR
1. STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Dorothy c. Herlth | | 2a. DATE OF DEATH MONTH DAY YEAR 01 10 86 | | 2b. HOUR 12:13 AM | |
| 3. SEX Female | 4. RACE C 1 | 5. DATE OF BIRTH MONTH DAY YEAR 05 01 12 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Hanover Gen | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY --- |
| 13a. STATE MARYLAND | 13b. COUNTY Baltimore | 13c. CITY OR TOWN BALTIMORE | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 1130 Cooksie St. 21230 |
| 14. FATHER'S NAME Carl | | 15. MOTHER'S MAIDEN NAME Ettie Daymond | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 219-20-7589 | | 17. INFORMANT Beverly Herlth 1130 Cooksie St. 21230 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>thrombocytopenic purpura</u> (c) <u>meningitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (this hospital) attended the deceased from <u>1/06</u> , 19 <u>86</u> , to <u>1/10</u> , 19 <u>86</u> , that (we) last saw the deceased alive on <u>1/10</u> , 19 <u>86</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) (go) (gp) (gq) (gr) (gs) (gt) (gu) (gv) (gw) (gx) (gy) (gz) (ha) (hb) (hc) (hd) (he) (hf) (hg) (hh) (hi) (hj) (hk) (hl) (hm) (hn) (ho) (hp) (hq) (hr) (hs) (ht) (hu) (hv) (hw) (hx) (hy) (hz) (ia) (ib) (ic) (id) (ie) (if) (ig) (ih) (ii) (ij) (ik) (il) (im) (in) (io) (ip) (iq) (ir) (is) (it) (iu) (iv) (iw) (ix) (iy) (iz) (ja) (jb) (jc) (jd) (je) (jf) (jg) (jh) (ji) (jj) (jk) (jl) (jm) (jn) (jo) (jp) (jq) (jr) (js) (jt) (ju) (jv) (jw) (jx) (jy) (jz) (ka) (kb) (kc) (kd) (ke) (kf) (kg) (kh) (ki) (kj) (kk) (kl) (km) (kn) (ko) (kp) (kq) (kr) (ks) (kt) (ku) (kv) (kw) (kx) (ky) (kz) (la) (lb) (lc) (ld) (le) (lf) (lg) (lh) (li) (lj) (lk) (ll) (lm) (ln) (lo) (lp) (lq) (lr) (ls) (lt) (lu) (lv) (lw) (lx) (ly) (lz) (ma) (mb) (mc) (md) (me) (mf) (mg) (mh) (mi) (mj) (mk) (ml) (mn) (mo) (mp) (mq) (mr) (ms) (mt) (mu) (mv) (mw) (mx) (my) (mz) (na) (nb) (nc) (nd) (ne) (nf) (ng) (nh) (ni) (nj) (nk) (nl) (nm) (nn) (no) (np) (nq) (nr) (ns) (nt) (nu) (nv) (nw) (nx) (ny) (nz) (oa) (ob) (oc) (od) (oe) (of) (og) (oh) (oi) (oj) (ok) (ol) (om) (on) (oo) (op) (oq) (or) (os) (ot) (ou) (ov) (ow) (ox) (oy) (oz) (pa) (pb) (pc) (pd) (pe) (pf) (pg) (ph) (pi) (pj) (pk) (pl) (pm) (pn) (po) (pp) (pq) (pr) (ps) (pt) (pu) (pv) (pw) (px) (py) (pz) (qa) (qb) (qc) (qd) (qe) (qf) (qg) (qh) (qi) (qj) (qk) (ql) (qm) (qn) (qo) (qp) (qq) (qr) (qs) (qt) (qu) (qv) (qw) (qx) (qy) (qz) (ra) (rb) (rc) (rd) (re) (rf) (rg) (rh) (ri) (rj) (rk) (rl) (rm) (rn) (ro) (rp) (rq) (rr) (rs) (rt) (ru) (rv) (rw) (rx) (ry) (rz) (sa) (sb) (sc) (sd) (se) (sf) (sg) (sh) (si) (sj) (sk) (sl) (sm) (sn) (so) (sp) (sq) (sr) (ss) (st) (su) (sv) (sw) (sx) (sy) (sz) (ta) (tb) (tc) (td) (te) (tf) (tg) (th) (ti) (tj) (tk) (tl) (tm) (tn) (to) (tp) (tq) (tr) (ts) (tt) (tu) (tv) (tw) (tx) (ty) (tz) (ua) (ub) (uc) (ud) (ue) (uf) (ug) (uh) (ui) (uj) (uk) (ul) (um) (un) (uo) (up) (uq) (ur) (us) (ut) (uu) (uv) (uw) (ux) (uy) (uz) (va) (vb) (vc) (vd) (ve) (vf) (vg) (vh) (vi) (vj) (vk) (vl) (vm) (vn) (vo) (vp) (vq) (vr) (vs) (vt) (vu) (vv) (vw) (vx) (vy) (vz) (wa) (wb) (wc) (wd) (we) (wf) (wg) (wh) (wi) (wj) (wk) (wl) (wm) (wn) (wo) (wp) (wq) (wr) (ws) (wt) (wu) (wv) (ww) (wx) (wy) (wz) (xa) (xb) (xc) (xd) (xe) (xf) (xg) (xh) (xi) (xj) (xk) (xl) (xm) (xn) (xo) (xp) (xq) (xr) (xs) (xt) (xu) (xv) (xw) (xx) (xy) (xz) (ya) (yb) (yc) (yd) (ye) (yf) (yg) (yh) (yi) (yj) (yk) (yl) (ym) (yn) (yo) (yp) (yq) (yr) (ys) (yt) (yu) (yv) (yw) (yx) (yy) (yz) (za) (zb) (zc) (zd) (ze) (zf) (zg) (zh) (zi) (zj) (zk) (zl) (zm) (zn) (zo) (zp) (zq) (zr) (zs) (zt) (zu) (zv) (zw) (zx) (zy) (zz) | | | | | |

MEDICAL CERTIFICATION

| | | | |
|--|----------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | 23b. DATE 1/11/86 | 23c. NAME OF CEMETERY OR CREMATORY Security Process Crem. | 23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Baltimore Md. |
| 24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. | | ADDRESS 21229 4107 Wilkens Ave. | 25a. DATE REC'D BY REGISTRAR JAN 13 1986 |
| 25b. REGISTRAR'S SIGNATURE | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

0

013020

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|---|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) ELEANOR ANNE HESSELBACHER | | | 2a. DATE OF DEATH MONTH DAY YEAR JAN 07, 1986 | | | 2b. HOUR 5:15 P.M. | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR FEB 25 1985 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS - 10 12 | | # UNDER 24 HRS. HOURS MIN. - | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO, MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3207 ABELL AVE | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) INFANT | | 12b. KIND OF BUSINESS OR INDUSTRY - | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13e. STREET ADDRESS 3207 ABELL AVE 21218 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ROBERT WILLIAM HESSELBACHER | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNE ELIZABETH GRAY | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) - | | 17. INFORMANT ADDRESS ANNE G. HESSELBACHER, SAME | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 110 mins | |
| DUE TO, OR AS A CONSEQUENCE OF (b) CARDIAC ARREST | | | | | | | | 15 mins | |
| DUE TO, OR AS A CONSEQUENCE OF (c) WENDTIG-HOFFMAN DISEASE | | | | | | | | 10 mos | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from SEP 15, 1985 , to JAN 7, 1986 , that (2) (we) last saw the deceased alive on DEC 3, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (3) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Brian Allstrom, MD | | | | | | DEGREE MD | | 22c. DATE SIGNED 1/7/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Brian Allstrom | | | | | | 22e. ADDRESS 22 SOUTH GREENE STREET, BALTIMORE | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | 23b. DATE 1/8/86 | | 23c. NAME OF CEMETERY OR CREMATORY Green Mount | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto., MD | | |
| 24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 9 1986 | | | |
| 4905 York Road Balto., MD 21212 | | | | | | 25b. REGISTRAR'S SIGNATURE <i>John W. Jenkins</i> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please bring this and pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

036175

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01155

| | | | |
|--|--|---|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) JOHN HENRY HEUSLER, Sr. | | 2a. DATE OF DEATH MONTH DAY YEAR 1 29 86 2b. HOUR 11:42 ^{AM} | |
| 3. SEX MALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR 4 21 1903 | |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SAINT AGNES HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SUPERVISOR - Gas & Elec. Co. | |
| 13a. STATE MARYLAND | | 13b. CITY OR TOWN BALTIMORE | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Henry | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothea Franz | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 001-95-8632 | |
| 17. INFORMANT Tony J. Bechler | | ADDRESS 36 Colony Hill Ct. - Balto., Md. #21227 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last: (b): (c): Cardiac arrest Ventricular Fibrillation Myocardial Infarction | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11 P.M. 1-29 1986 | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 21g. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-16-86 19 to 1-29 19 86 that (I) (we) lost the deceased alive on 1-29 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE Gregory S. Gordon | | 22c. DATE SIGNED 1-30-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gregory S. Gordon | | 22e. ADDRESS St. Agnes Hosp. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Feb. 1, 1986 | |
| 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md. | |
| 24. FUNERAL DIRECTOR NAME G. Truman Schwartz | | 25a. DATE REC'D. BY REGISTRAR FEB 03 1986 | |
| 25b. REGISTRAR'S SIGNATURE John Davidson-Randall | | | |

MEDICAL CERTIFICATION

35
40
38
030
2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

013027

1- FOR
STATE
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Dorothy E. Hill</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>1 6 86</i> | | | 2b. HOUR <i>2:18 AM</i> | |
| 3. SEX <i>Female</i> | | 4. RACE <i>Black</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>9 5 1915</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>71</i> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>N.J.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore</i> MD. | |
| 10. CITY OR TOWN OF DEATH <i>BALT. Md</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Provident Hospital</i> | | | | 12a. USUAL OCCUPATION (TYPE OF MOST OF WORKING LIFE) <i>NURSE</i> | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |

| | | | | | | | |
|---|--|-----------------------------|--|---|--|--|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE <i>6800 Liberty Rd. Balt. Md 21207</i> | |
| 13a. STATE <i>MARYLAND</i> | | 13b. COUNTY <i>Balto</i> | | 13c. CITY OR TOWN <i>BALTIMORE</i> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>CHARLES ENGLISH</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>FLORENCE CRIPPEN</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO</i> | | | | 16b. SOCIAL SECURITY NO. <i>106-12-8042</i> <i>577241234</i> | | 17. INFORMANT ADDRESS <i>Quamina 21215</i> <i>HECTOR QUAMINA 4221 RIDGEWOOD AVE.</i> | |

| | | | |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Pulmonary Disease</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Respiratory Failure</i> | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>Possible CVA.</i> | | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: *NO*

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1-5</i> 19 <i>86</i> , to <i>1-6</i> 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>1-6</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (ed) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>J.M. Baustian</i> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J.M. Baustian</i> | | | | 22e. ADDRESS <i>Provident Hospital, BALT. MD.</i> | | | |

| | | | | | | | |
|--|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i> | | 23b. DATE <i>1-10-86</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>WOODLAWN</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>BALTIMORE COUNTY MD.</i> | |
| 24. FUNERAL DIRECTOR NAME ADDRESS <i>WM.C. MARCH F/H INC. 1101 E. NORTH AVE.</i> | | | | 25a. DATE REC'D. BY REGISTRAR <i>JAN 9 1986</i> | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

020046

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01157

| | | | |
|--|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | |
| EDWARD JAMES HILL | | JANUARY 10, 1986 | |
| 3. SEX M | | 4. RACE B | |
| 5. DATE OF BIRTH MONTH DAY YEAR 11 29 09 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER BALTIMORE | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION) MARYLAND | | 13b. COUNTY BALTIMORE | |
| 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE 1660 CLIFTVIEW AVE. 21213 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST EDWARD HILL | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH RAY | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218 07 9289 | |
| 17. INFORMANT ADDRESS GERTUDE HAMILTON 1627 CLIFTVIEW AVE. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARDIOGENIC & SEPTIC SHOCK, RENAL FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>MALNUTRITION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a. <u>Proble CVA, Proble Pulmonary Embulus</u> | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (this hospital) attended the deceased from <u>Dec. 31, 1985</u> to <u>Jan. 10, 1986</u> , that (we) last saw the deceased alive on <u>Jan. 10, 1986</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If a medical examiner viewed the body after death, so state.) | | | |
| 22b. SIGNATURE <i>[Signature]</i> MD | | 22c. DATE SIGNED <u>1/10/86</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Glessman</u> | | 22e. ADDRESS 3900 Loch Raven Blvd. Baltimore Md 21218 | |
| 23a. BURIAL, CREMATION, REMOVAL (IF CREMATION, GIVE DATE) | | 23b. DATE 1-16-86 | |
| 23c. NAME OF CEMETERY OR CREMATORY GARRISON FOREST | | 23d. LOCATION CITY OR TOWN COUNTY STATE OWING MILLS MARYLAND | |
| 24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H INC. 1101 E. NORTH AVE. | | 25a. DATE REC'D. BY REGISTRAR JAN 16 1986 | |
| 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

MEDICAL CERTIFICATION

99

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified in writing.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|---|--|--|---|--|--|---|--|--|---|--|--|------------------------|--|--|---------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST JAMES | | | MIDDLE W. | | | LAST HILL, SR | | | 2a. DATE KNOWN OF DEATH ESTIMATED | | | MONTH 1 | | | DAY 7 | | | YEAR 19 86 | | | 2b. HOUR M | | |
| 3. SEX MALE | | | 4. RACE Black | | | 5. DATE OF BIRTH MONTH DAY YEAR 01-05-27 59 | | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. | | | IF UNDER 1 YR. MONTHS DAYS | | | IF UNDER 24 HRS. HOURS MIN | | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 7 19 86 | | | 2d. HOUR M 11:45 | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO., MD | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | | 12b. KIND OF BUSINESS OR INDUSTRY J.H.H. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2911 Boarman Ave. | | | 13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13b. STREET ADDRESS 1116 RIGGS AVENUE | | | 13c. CITY OR TOWN Baltimore | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS 1116 RIGGS AVENUE | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Hill | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Le Compt | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATE) 1945-1947 | | | 17. INFORMANT Margaret Brooks | | | ADDRESS 1116 Riggs Ave. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive & arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Ann M. Dixon, M.D. | | | TITLE (SPECIFY) M.D. Assistant | | | MEDICAL EXAMINER | | | DATE SIGNED 1-8-86 | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | ADDRESS 111 Penn St., Balto., MD 21201 | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1-13-86 | | | 23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Vet | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills Md. | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR William C. March E.H. | | | ADDRESS West 4300 Walsh | | | 25a. DATE REC'D. BY REGISTRAR JAN 13 1986 | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | |

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH PAGES 1, 2, AND 3. PAGES 1, 2, AND 3 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

042053

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|--|---|--|--|--|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) LEONARD | | | FIRST MIDDLE LAST HILL | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 26 1986 | | | 2b. HOUR 1:15 P.M. | | |
| 3. SEX Male | | | 4. RACE Black | | | 5. DATE OF BIRTH MONTH DAY YEAR 9 3 14 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH Balto. | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Charles General Hosp. | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | | 13b. COUNTY Balto. | | | 13c. CITY OR TOWN Balto. | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Unkn | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unkn | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO Unkn | | |
| 17. INFORMANT ADDRESS Nellie Hannah 2517 Liberty Hgts | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio-pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) septic shock DUE TO, OR AS A CONSEQUENCE OF (c) Bilateral pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Atherosclerotic heart disease | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/20/1986 to 1/26/1986 , that (I) (we) last saw the deceased alive on 1/25/1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | 22b. SIGNATURE KIRTIKANT I DESAI DEGREE | | | 22c. DATE SIGNED | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) KIRTIKANT I DESAI | | | 22e. ADDRESS North Charles Hospital / Baltimore MD | | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 2/6/86 | | |
| 23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cem. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Landsdown, Md. | | | 24. FUNERAL DIRECTOR NAME Wm C March F/H West ADDRESS 4300 Wabash Ave | | | 25a. DATE REC'D. BY REGISTRAR FEB 07 1986 25b. REGISTRAR'S SIGNATURE Jane Gordon-Hendall | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 must be filed in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
STATE
REGISTRAR

AKA/ REBECCA M. HINKEL

REG. NO.

| | | | | | | | |
|---|--|---|---|--|----------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) HINKEL REBECCA | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 18 86 | | 2b. HOUR 6:00 AM | | |
| 3 SEX FEMALE | | 4 RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 10 26 1887 | | 6 AGE (IN YEARS LAST BIRTHDAY) 98 YRS MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | |
| 10 CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SEAMSTRESS | | 12b. KIND OF BUSINESS OR INDUSTRY GARMENT | |
| 13a. STATE MARYLAND | | 13b. COUNTY MONTGOMERY | | 13c. CITY OR TOWN SILVER SPRING | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST SAMUEL HINKEL | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MIRANDA AMANDA HINKEL | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 212-28-9054 | |
| 17 INFORMANT ADDRESS MRS. ALICE H. MADDRIX 4 FINSBURY PARK COURT | | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Cardiovascular Disease. DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/11/86 , 19 86 , to 1/18 , 19 86 , that (I) (we) last saw the deceased alive on 1/17 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Shanti | | DEGREE | | 22c. DATE SIGNED 1/18/86 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHANTI RAMESH | |
| 22e. ADDRESS St. Agnes Hospital 900 Caton Ave, Baltimore, MD 21229 | | 23a. BURIAL, CREMATION, REMOVAL BURIAL | | | | | |
| 23b. DATE 01/21/86 | | 23c. NAME OF CEMETERY OR CREMATORY CHRIST CHURCH CEMETERY | | 23d. LOCATION TOWNSHIP COUNTY STATE STOUCHBURG BERKS PENNSYLVANIA | | | |
| 24 FUNERAL DIRECTOR NAME AMBROSE FUNERAL HOME 1328 SULPHUR SPRING ROAD | | 25a. DATE REC'D. BY REGISTRAR JAN 21 1986 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--|---|---|--|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) GEORGE A. HINSHAW | | | 2a. DATE OF DEATH MONTH DAY YEAR 1/29/85 | | | 2b. HOUR 12:16 P.M. | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 09 02 04 | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOOD SAMARITAN HOSP. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Store Manager | | 12b. KIND OF BUSINESS OR INDUSTRY Variety Store | |
| 13a. STATE Maryland | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Towson | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph N. Hinshaw | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jennie Thornton | | | 13e. STREET ADDRESS / ZIP CODE 500 Virginia Ave. 21204 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 550-07-8849 | | 17. INFORMANT ADDRESS Russell W. Hinshaw, Sr. - 9 Kingcrest Ct., Apt D 21207 | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrhythmia DUE TO, OR AS A CONSEQUENCE OF (b) 2° dilated cardiomyopathy. A-F. DUE TO, OR AS A CONSEQUENCE OF (c) CHF peripheral neuropathy PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/29/86 to 1/29/86 , that (I) (we) last saw the deceased alive on 1/29/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Shahida Siddiqi | | | DEGREE MD | | | 22c. DATE SIGNED 1/29 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHAHIDA SIDDIQI | | | 22e. ADDRESS GOOD SAMARITAN HOSP. LOCHRAVEN BLVD BALTI. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 2-1-86 | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood | | 23d. LOCATION CITY OR TOWN COUNTY STATE Parkville, Balto., Md. | | |
| 24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. | | | ADDRESS 1050 York Rd. Towson, Md. 21204 | | | 25a. DATE REC'D. BY REGISTRAR JAN 31 1986 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

MEDICAL CERTIFICATION

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FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FLORENCE ANNA HIRT | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 5 1986 | | 2b. HOUR 9:10 M |
| 3. SEX FEMALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR JULY 26 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4505 PARKWOOD AVE. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK | 12b. KIND OF BUSINESS OR INDUSTRY - | |
| 13a. STATE MD. | 13b. COUNTY | 13c. CITY OR TOWN BALTIMORE | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 4505 PARKWOOD AVE. 21206 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH HIRT | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CHRISTINA PANUSKA | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-09-2750 | 17. INFORMANT ADDRESS SAME EILEEN HIRT (SISTER-IN-LAW) ADDRESS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive C.V.D.</u> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Months</u> <u>25 years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a- | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>19 60</u> to <u>Jan. 19 86</u> , that (I) (we) lost saw the deceased alive on <u>Dec 18</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Harold Burns</u> | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1-6-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. HAROLD BURNS | | 22e. ADDRESS 8106 HARFORD RD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE 1/8/86 | 23c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER | | 23d. LOCATION CITY OR TOWN COUNTY BALTIMORE MD. | |
| 24. FUNERAL HOME NAME SCHTMUNEK FUNERAL HOME, INC. 3331 Brehms Lane, Balto. Md. 21213 | | 25a. DATE REC'D. BY REGISTRAR JAN 7 1986 25b. REGISTRAR'S SIGNATURE <u>John Davidson</u> | | | |

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RABBIT NO 1000000



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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|-------------------------|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) MARGARET M. HITT | | 2a. DATE OF DEATH MONTH 1 DAY 14 YEAR 86 | | 2b. HOUR 8:01 AM | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH 3 DAY 6 YEAR 04 | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North General General 21218 | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE Maryland | | 12b. COUNTY Baltimore | | 12c. CITY OR TOWN Baltimore | |
| 13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13b. STREET ADDRESS / ZIP CODE 4113 1/2 Buchanan Ave. 21211 | | 13c. KIND OF BUSINESS OR INDUSTRY Housewife | |
| 14. FATHER'S NAME FIRST William MIDDLE Brown LAST Brown | | 15. MOTHER'S MAIDEN NAME FIRST (unknown) MIDDLE (unknown) LAST (unknown) | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | |
| 16b. SOCIAL SECURITY NO. 214-14-2863 | | 17. INFORMANT Lester Hitt 3300 Falls Road 21211 | | 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF PANCREAS DUE TO, OR AS A CONSEQUENCE OF (b) POSSIBLE SEPTICEMIA & UTI DUE TO, OR AS A CONSEQUENCE OF (c) ARTHEROSLEROTIC HEART DISEASE | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (hus/hospital) attended the deceased from 1/13 19 86 to 1/14 19 86 , that (I) (we) lost saw the deceased alive on 1/14 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE A.C. Chouvalit, M.D. | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.C. CHOUVALIT, M.D. | | 22e. ADDRESS NORTH CHARLES GEN. HOSP. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/18/86 | | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk. | |
| 23d. LOCATION CITY OR TOWN Baltimore | | COUNTY Maryland | | STATE Maryland | |
| 24. FUNERAL DIRECTOR NAME A. Alan Seitz, Jr. | | ADDRESS 3615-19 Chestnut Ave. 21211 | | 25a. DATE REC'D. BY REGISTRAR JAN 16 1986 | |
| 25b. REGISTRAR'S SIGNATURE | | | | | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

035080

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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|---|--|--|--|---|---|--|--|--|--|---------------------|--|
| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 01164 | |
| 1. DECEASED NAME (TYPE OR PRINT) BENJAMIN H. HOARE | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1/30/86 | | | | | 2b. HOUR 1:28 PM | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 11 01 10 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL 21218 | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY -- 13c. CITY OR TOWN Baltimore | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 4405 Falls Road 21211 | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST (unknown) | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (unknown) | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II | | 16c. SOCIAL SECURITY NO. 144-14-4589 | | 17. INFORMANT ADDRESS Mary J. Spangler 4401 Falls Road 21211 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Pul. decompensation</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>COPD / Metastatic adenocarcinoma of prostate</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Hx of Thoracic and abd. aortic aneurysm</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/30</u> , 19 <u>86</u> , to <u>1/30</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>1/30</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>L.S. FARRUKH</u> | | | | | DEGREE <u>MD</u> | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <u>1/30/86</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>IMAD S. FARRUKH</u> | | | | | 22e. ADDRESS <u>UNION MEMORIAL Hosp. Balt. MD 21218</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | 23b. DATE 1/31/86 | | 23c. NAME OF CEMETERY OR CREMATORY Green Mount Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS A. Alan Seitz, Jr. 3818 Roland Ave. 21211 | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 31 1986 | | 25b. REGISTRAR'S SIGNATURE <u>Donald Anderson-Randall</u> | | | | |

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2025 COLLECTION

WILSON 121117

JAN 31 2025

020011

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M
 BP
DHMH - 17
(VR A15 ME (5))

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|-------------------------------------|--|---|--|--|--|---|--|---|--|
| 1- STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME FIRST MIDDLE LAST Joseph Michael Hobbs | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 1 9 19 86 | |
| 3. SEX male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 6 12 49 | | 6. AGE (IN YEARS LAST BIRTHDAY) 36 YRS. | | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | | 2b. DATE PRONOUNCED DEAD 1 9 19 86 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD | | 2d. HOUR 5 AM | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) unemployed | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Md. | | 13b. CITY OR TOWN Balto. City | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1656 Belvedere Ave. | | 21239 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Thomas Hobbs | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Della Miller ### | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 583-32-1273 | | 17. INFORMANT ADDRESS Della Hobbs 303 Mt. Zoar Rd. Conowingo Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intravenous narcotism DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Dennis F. Smyth | | | | TITLE (SPECIFY) M.D. Assistant | | | | DATE SIGNED 1/9/86 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. | | | | ADDRESS 111 Penn St. Balto, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 1-11-86 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Zoar AME | | 23d. LOCATION CITY OR TOWN COUNTY STATE Conowingo Cecil Md. | | | |
| 24. FUNERAL DIRECTOR NAME Arnold Beard | | | | ADDRESS 353 Fountain St. Havre de Grace, Md. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 16 1986 | | 25b. REGISTRAR'S SIGNATURE Lelia Davidson-Randall | |

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FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|---|---|---|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Richard Paul Hoerl | | | 2a. DATE OF DEATH MONTH DAY YEAR 1-1-86 | | 2b. HOUR 07:43M | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 7-4-49 | 6. AGE (IN YEARS LAST BIRTHDAY) 36 YRS. | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 36 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital, Balto., Md. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic | 12b. KIND OF BUSINESS OR INDUSTRY Self Employed | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 300 Bloomsbury Ave. 21228 | |
| FATHER'S NAME FIRST MIDDLE LAST Marshall Hoerl | | MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Nora Wheatley | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-48-0689 | 17. INFORMANT 21228 ADDRESS Catonsville, MD Mrs. Ella Nora Hoerl 300 Bloomsbury A | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 10/25 1984 to January 1986 , that (1) (we) lost saw the deceased above (1) (we) (did) (did not) view the body after death. and that in my (our) opinion death occurred on the date and hour and from the causes stated | | | | | | |
| 22b. SIGNATURE Patrick W. White | | | DEGREE M.D. | | 22c. DATE SIGNED 1/2/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Patrick W. White | | | 22e. ADDRESS 299 Frederick Rd., Balt. Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | 23b. DATE 01-02-85 | 23c. NAME OF CEMETERY OR CREMATORY Security Process | 23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville, Balto. MD | | | |
| 24. FUNERAL DIRECTOR NAME Cremation Society of MD | | | 25a. DATE REC'D. BY REGISTRAR JAN 10 1986 | 25b. REGISTRAR'S SIGNATURE John W. White | | |

011012

Michael Paul Jones

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100% COTTON

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Handwritten text at the bottom of the page, possibly a signature or address, including the word "Michael".

020021

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|---|---|---|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) GLORIA E. HOERNLEIN | | | 2a. DATE OF DEATH MONTH DAY YEAR JAN, 8, 1986 | | | 2b. HOUR 1:20P M | | | |
| 3 SEX FEMALE | | 4 RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR JULY 17, 1932 | | 6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AT HOME | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | | 13b. CITY OR TOWN BALTIMORE | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13d. STREET ADDRESS / ZIP CODE 6202 RIDGEVIEW AVE. 21222 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM AMOS KIRKENDALL | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DOROTHY E. JOHNSON | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 21734 6150 | | 17. INFORMANT ADDRESS FAMILY RECORDS | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY SPASM DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 MIN | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:1a | | | | | | | | | |
| 19a. DATE OF OPERATION 1/6/86 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CORONARY ARTERY DIS | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/29, 1985, to 1/8, 1986, that (I) (we) last saw the deceased alive on 1-8-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Peter Horngatter | | | | | | DEGREE M.D. | | 22c. DATE SIGNED 1/8/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) PETER HORNGATTER | | | | | | 22e. ADDRESS 600 N WOLF ST BALTO, MD. 21205 JOHNS HOPKINS HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE Jan. 13, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Parkville BALTO. MARYLAND | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS EVANS CHAPL OF MEMORIAL HARFORD | | | | | | 25a. DATE REC'D BY REGISTRAR JAN 16 1986 | | | |

MEDICAL CERTIFICATION

9

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been assigned by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Page 4 should be retained by the funeral director. Page 5 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, giving the medical examiner the opportunity to investigate.

TO BALTIMORE CITY OR COUNTY HEALTH DEPARTMENT: This certificate is required for the registration of the death. It should be filed with the death record within 72 hours after death.

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|--|--|--|---|
| 1 DECEASED NAME (TYPE OR PRINT) FRANCIS Thomas HOGAN | | | 2a DATE OF DEATH MONTH DAY YEAR January 21, 1986 | | 2b HOUR 6:36 P M |
| 3 SEX Male | 4 RACE White | 5 DATE OF BIRTH MONTH DAY YEAR December 22, 1904 | 6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS | | 7 UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 8a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b CITIZEN OF WHAT COUNTRY? United States | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE City MD. | | |
| 10 CITY OR TOWN OF DEATH BALTIMORE CITY | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Group Leader | 12b KIND OF BUSINESS OR INDUSTRY Balto. Gas & Elec | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland | | 13b COUNTY Baltimore | 13c CITY OR TOWN Baltimore | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Thomas Francis Hogan | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Charlotte Rebstock | | 13e STREET ADDRESS / ZIP CODE 1303 East Northern Parkway 21239 | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b SOCIAL SECURITY NO. 214-14-8847 | | 17 INFORMANT ADDRESS Bettie Hogan Saltzman 1305 E. Northern Parkway 21239 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF: (b) CHF with Rt. hemiplegy DUE TO, OR AS A CONSEQUENCE OF: (c) Pneumonia, CHF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a ASCVD Diabetes mellitus occlusive peripheral vascular disease | | | | | |
| 19a DATE OF EXAMINATION Jan 20 1986 | | 19b EXAMINATION FOR WHICH CERTIFICATION WAS PERFORMED Autopsy | | 19c IF FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21a TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21b PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.) | 21i LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a I certify that (I) (this hospital) attended the deceased from Dec 27 1985 to January 19 1986 , that (I) (we) last saw the deceased alive on Jan 20 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do) view the body after death. | | | | | |
| 22b SIGNATURE J. W. F. Zimm, MD | | DEGREE MD | | 22c DATE SIGNED Jan 24 1986 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) J. W. F. Zimm, MD | | 22e ADDRESS 8014 Old Harford Rd Baltimore | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b DATE January 25, 1986 | 23c NAME OF CEMETERY OR CREMATORY Dulaney Valley | 23d LOCATION CITY OR TOWN COUNTY STATE Cockeysville Baltimore Maryland | | |
| 24 FUNERAL DIRECTOR NAME ADDRESS Mitchell-Wiedefeld Funeral Home 6500 York Road | | 25a DATE REC'D. BY REGISTRAR JAN 24 1986 | | | |
| | | 25b REGISTRAR'S SIGNATURE [Signature] | | | |

Discussion

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STATE OF MARYLAND 8 6 6 0 1 1 6 9

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|-------------|--|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) JOSEPH <i>JOSEPH</i> HOLMES <i>HOLMES</i> | | | 2a DATE OF DEATH MONTH DAY YEAR JANUARY 25, 1986 / 25 / 86 | | 2b HOUR 11:01 PM |
| 3 SEX M | 4 RACE B | 5. DATE OF BIRTH MONTH DAY YEAR 4 8 17 | 6 AGE (IN YEARS LAST BIRTHDAY) 68 YRS | 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA. | 7b CITIZEN OF WHAT COUNTRY? U.S.A. |
| 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE, CITY MD. | | | |
| 10 CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHURCH HOSPITAL | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BETH/ STEEL | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a STATE MARYLAND | | | 13b COUNTY | 13c CITY OR TOWN BALTIMORE | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14 FATHER'S NAME FIRST MIDDLE LAST JOSEPH HOLMES | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EDNA THOMAS | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b SOCIAL SECURITY NO. 218-05-5199 | | 17 INFORMANT ADDRESS BEATRICE HOLMES 2817 E. BIDDLE ST. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>STATUS POST MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>JANUARY 23, 1986</u> , to <u>JANUARY 25, 1986</u> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <u>JANUARY 25, 1986</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (If the physician did not view the body after death, so state.) | | | | | |
| 22b. SIGNATURE <i>Bram</i> | | DEGREE MD | | 22c. DATE SIGNED 1/25/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRAM TRICKERMAN | | 22e. ADDRESS CITIZEN HOSPITAL | | 22f. CITY OR TOWN BALTIMORE, MD. 21231 | |
| 23a. BURIAL, CREMATION, REMOVAL (CHECK ONE) BURIAL | | 23b. DATE 1-30-86 | | 23c. NAME OF CEMETERY OR CREMATORY ARBUTUS | |
| 23d. LOCATION CITY OR TOWN ARBUTUS | | 23e. COUNTY MARYLAND | | 23f. STATE | |
| 24 FUNERAL DIRECTOR NAME March J.H. | | 24b. ADDRESS 1101 E North Ave | | 25a. DATE REC'D. BY REGISTRAR JAN 29 1986 | |
| 25b. REGISTRAR'S SIGNATURE <i>ma Davidson-Randall</i> | | | | | |

MEDICAL CERTIFICATION

MEDICAL CERTIFICATION: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a separate report filed.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01170

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) ALONZO JENNINGS HOMILY | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 12 86 | | 2b. HOUR MIN. 11 53 P.M. | | | | |
| 3. SEX male | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR JAN. 19, 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) MD. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY of MD. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SHIP REPAIR | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Q.A. 13c. CITY OR TOWN CHESAPEAKE | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE R.F.D. #1 21628 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM HOMILY | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST REBECCA | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES (IF YES, GIVE WAR OR DATES) WW II | | | | 16b. SOCIAL SECURITY NO. 157-01-2223 | | 17. INFORMANT NAME ADDRESS MRS. MARY L. CRUMPTON, MRS. L. PO BOX #28 CRUMPTON, MD. 21628 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) POSSIBLE SEPSIS DUE TO, OR AS A CONSEQUENCE OF (c) POSSIBLE AORTIC DISSECTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/12 , 19 86 , to 1/12 , 19 86 , that (I) (we) last saw the deceased alive on 1/12 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Ludwig J. Eglsecker MD | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/12/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ludwig J. Eglsecker MD | | | | | | 22e. ADDRESS University of Maryland Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL BURIAL | | | 23b. DATE 1-17-1986 | | 23c. NAME OF CEMETERY OR CREMATORY HILLSIDE CEM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE ROSYN PA. | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS James W. [unclear] CHESTERTOWN | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 22 1986 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, or medical condition, the attending physician must complete this section.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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008159

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01171

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--------------------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Angela T Hooper</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>1 5 86</i> | | 2b. HOUR <i>8⁰⁰ AM</i> | | |
| 3. SEX <i>Female</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>10 31 28</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>57</i> YRS | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore city</i> MD. | |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>University of Maryland</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE <i>MD</i> | | 13b. COUNTY | | 13c. CITY OR TOWN <i>Balto.</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>John T. Potts</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Adrian Beatrice</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. <i>214-24-4777</i> | |
| 17. INFORMANT ADDRESS <i>Mr. Richard Hooper Same as #13e</i> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Malignant melanoma</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 yrs</i> | | | |

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1230</i> <i>19 85</i> to <i>1/5</i> <i>19 86</i> that (we) last saw the deceased alive on <i>1/5</i> <i>19 86</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>W. Beck MD</i> | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <i>1/5/86</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>WALTER Beck JR</i> | | 22e. ADDRESS <i>22 S. Greene St. Balto. MD 21209</i> | | | | | |

| | | | | | | | |
|---|--|----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>1-8-86</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Crest Lawn</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Howard, Maryland</i> | |
| 24. FUNERAL DIRECTOR NAME <i>Leonard J. Ruck, Inc. Baltimore, Md.</i> | | | | 25a. DATE REC'D. BY REGISTRAR <i>JAN 6 1986</i> | | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the records of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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023003

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|---------|--|------------------------------------|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH KNOWN ESTI- MATED | | | | 2b. HOUR | | | |
| Jerome S. Hopewell | | | | 1/ 25/19 86 | | | | 2:09 | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YR. MONTHS DAYS | | 7c. DATE PRONOUNCED DEAD | | 7d. HOUR | | 7e. MIN. | |
| male | black | 6 13 1944 | 41 YRS. | | | 1/ 25/1986 | | A | | M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Md | | U S A | | | | Baltimore City, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | 4400 Blk. Haddon Ave. | | | | Unemployed | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| Md | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 3916 W. Coldspring Lane 21215 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | |
| Paul Hopewell | | | | Cecelia | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| No | | | | 214-44-1692 | | Cecelia Hopewell 3916 W. Coldspring Lane | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Gunshot Wounds</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| | | | | 2:00xx 1/25/ 19 86 | | subject shot | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | street | | 4400 Blk. Haddon Ave., Balto. City, Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held an: Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 1/25/86 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | |
| Gregory R. Kauffman, M.D. | | | | 111 Penn St. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | 1/30/86 | | Mt Auburn Cemetery | | Baltimore | | Md | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | | | 25a. DATE REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| William C. March F/H West 4300 Wabash Avenue | | | | | | JAN 27 1986 | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1, 2, AND 3 SHOULD BE FILED, WITHIN 72 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | |
|--|--|---------|-------------------|--|--|--|--|---|--|--|--|---|--|-------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE KNOWN OF DEATH ESTI. MATED | | | | XX MONTH DAY YEAR | | | | 2b. HOUR | |
| Mary A Hopkin | | | | | | 1-12 19 86 | | | | | | | | M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | | 7c. DATE PRONOUNCED DEAD | | | | 2d. HOUR | |
| Female | | white | | Jan 23, 1901 | | 84 YRS. | | | | 1-12 19 86 | | | | 12:14 P. M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | | | U.S.A. | | | | | | | | Baltimore City, MD. | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | | | St. Agnes Hospital | | | | | | | | | | | |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? 13e. STREET ADDRESS | | | | | | | | | | | | | | | |
| Maryland | | | | Howard | | Ellicott City | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 3138 Rogers Ave., 21043 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | |
| William Adams | | | | | | | | Mary O'Connor | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | |
| No | | | | | | | | | | | | William R Hopkin 3138 Rogers Ave., 21043 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Gastrointestinal Hemorrhage</u> | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) Assistant | | | | | | | | DATE SIGNED 1-13-86 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | |
| Dennis F. Smyth, M.D. | | | | 111 Penn St., Balto., Md. | | | | | | | | 21201 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Cremation | | | | Jan 13, 1986 | | | | Westview Memorial pk | | | | Catonsville Balto., Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Harry H Witzke & Family Funeral Home Inc 4112 Old Columbia Pike ellicott City | | | | | | | | | | | | | | | |
| 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 21 1986 | | | | | | | | | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND 6 01174 | | | | | | | | | |
|---|--|--|--|---|---|--|--|----------------------------------|--|
| 1 - STATE REGISTRAR | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) | | | | | 2a DATE OF DEATH | | | | |
| Daisy L. Hopkins | | | | | 1 24 86 9 45 AM | | | | |
| 2 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7b IF UNDER 1 YEAR | |
| FEMALE | | BLACK | | 2 1 22 | | 63 YRS | | MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | |
| VIRGINIA | | US | | | | BMT. City MD. | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | | Mercy Hosp | | | | housewife | | | |
| 13a STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | | 13e STREET ADDRESS | |
| MD | | | | BALT. | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 2208 Barclay St. | |
| 14 FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | |
| EDDIE GEE | | | | | SUSIE | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | | 16b SOCIAL SECURITY NO. | | | | |
| NO | | | | | 216-18-9404 | | | | |
| 17 INFORMANT | | | | | ADDRESS | | | | |
| ANDREW HOPKINS | | | | | 2208 BARCLAY STREET | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Esophageal cancer | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a DATE OF OPERATION | | | | | | | | | |
| 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | |
| 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | |
| 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | | | | |
| 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | | | | | | |
| 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | | | | | |
| 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 8/13 19 86 to 1/24 19 86 that (I) (we) last saw the deceased alive on 1/24 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE DEGREE | | | | | | | | | |
| Michael E. Cox MD | | | | | | | | | |
| 22c DATE SIGNED 1/24/86 | | | | | | | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | |
| ME COX | | | | | | | | | |
| 22e ADDRESS | | | | | | | | | |
| Mercy Hospital | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | | | | | |
| BURIAL | | | | | | | | | |
| 23b DATE 01-28-86 | | | | | | | | | |
| 23c NAME OF CEMETERY OR CREMATORY | | | | | | | | | |
| KINGS MEMORIAL PARK | | | | | | | | | |
| 23d LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | |
| BALTIMORE, MARYLAND | | | | | | | | | |
| 24 FUNERAL DIRECTOR | | | | | | | | | |
| BROWN/THOMPSON F.H. 1913 W. BALTIMORE ST. | | | | | | | | | |
| 25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE | | | | | | | | | |
| JAN 27 1986 | | | | | | | | | |

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WASHINGTON
Baltimore

OFFICE

NOTE

218-12-2404 WORKING 2224 EASTMAN STREET

NO

RECEIVED AT SHORE E. J. 1013 W. BALTIMORE ST.
JAN 10 11 11-11 KING'S REPORTING FIRM BALTIMORE, MARYLAND


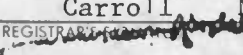
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | |
|---|--|-----------------|-----------------|--|--|---|--|---|---------------|---|--|---|--|--|------------------------------|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST Robert | | | MIDDLE C. | | | LAST Hopps | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1/ 23/19 86 | | | 2b. HOUR M 4:35 P M | | | | |
| 3. SEX Male | | 4. RACE Cau. | | 5. DATE OF BIRTH MONTH DAY YEAR 2 24 26 | | 6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7c. DATE PRONOUNCED DEAD 1/ 23/19 86 | | | 7d. HOUR P M | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6418 Rosemont Ave. | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lottery - State Of | | | | 12b. KIND OF BUSINESS OR INDUSTRY Md. | | | | | |
| 13a. STATE Md. | | | | | | 13b. COUNTY - | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 6418 Rosemont Ave. 21206 | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William I. Hopps | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Frances Etzel | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | | | (IF YES, GIVE WAR OR DATES) W.W.II | | | | 16b. SOCIAL SECURITY NO. 214-20-1648 | | | | 17. INFORMANT ADDRESS Millicent L. Hopps 6418 Rosemont Ave. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Hypertensive Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. <u>Coronary Obstructive Pulmonary Disease; Alzheimers Disease</u> | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | | | | | | | | | | | DATE SIGNED 1/24/86 | |
| EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. | | | | ADDRESS 111 Penn St. | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 1-27-86 | | | | 23c. NAME OF CEMETERY OR CREMATORY Lake View Cem. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Eldersburg Carroll Md. | | | | | | | |
| 24. FUNERAL DIRECTOR NAME John C. Miller Inc. | | | | ADDRESS 6415 Belair Rd. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 28 1986 | | | | 25b. REGISTRAR'S SIGNATURE  | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the accompanying pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal death investigation is required.

MEDICAL CERTIFICATION

| | | | | | |
|---|-----------|------------------------------------|-------------------------------|--------|----------|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
| Burial | 1/20/86 | Loudon Park Cemetery | Baltimore | | Maryland |
| 24. FUNERAL DIRECTOR NAME | | | 25a. DATE REC'D. BY REGISTRAR | | |
| Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, MD. 21228 | | | JAN 17 1986 | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | |

| | | | | | | | | | | | | | | | | | |
|---|--|--|---|--|--|---|--|--|---|--|--|-----------------------------------|--|--|------------------|--|--|
| 1. FOR STATE REGISTRAR | | | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | REG. NO. 01176 | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | | 2a. DATE OF DEATH | | | | | | 2b. HOUR | | | | | |
| FIRST MIDDLE LAST CONSTANCE M. HORN | | | | | | MONTH DAY YEAR 1 16 86 | | | | | | 8:05 P.M. | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | | IF UNDER 24 HRS. | | |
| Female | | | White | | | MONTH DAY YEAR August 14, 1902 | | | 83 YRS. | | | MONTHS DAYS HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | |
| Maryland | | | U.S.A. | | | | | | Baltimore City MD. | | | | | | | | |
| 11. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Baltimore | | | St. Agnes Hospital | | | | | | Examiner | | | Garment Tailoring | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS / ZIP CODE | | | | | |
| Maryland | | | Baltimore | | | Catonsville | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 6121 Wheatland Road 21228 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | | | | | | | |
| Vincent Culotta | | | Rosa Liberto | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | 18. ADDRESS | | | | | | | | |
| No | | | 216-03-6851 | | | Angela E. Neary | | | 6218 Collinsway Road Catonsville, MD. 21228 | | | | | | | | |

| | | | |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | |
| IMMEDIATE CAUSE (a) <u>Cause pulmonary arrest</u> | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | |
| (b) <u>pulmonary edema</u> | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | |
| (c) <u>Myocardial infarction</u> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | |

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/6/86</u> , 19 <u>86</u> , to <u>11 16</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>8:05 1/16</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE <u>N. Nasir</u> | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MOKHTAR NASIR | | 22e. ADDRESS 8 LRAMBLING OAK WAY, BAL. MD 21228 | | | | | |

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REPORT NOT TO BE

THEY ARE NOT TO BE



1 - FOR
STATE
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO

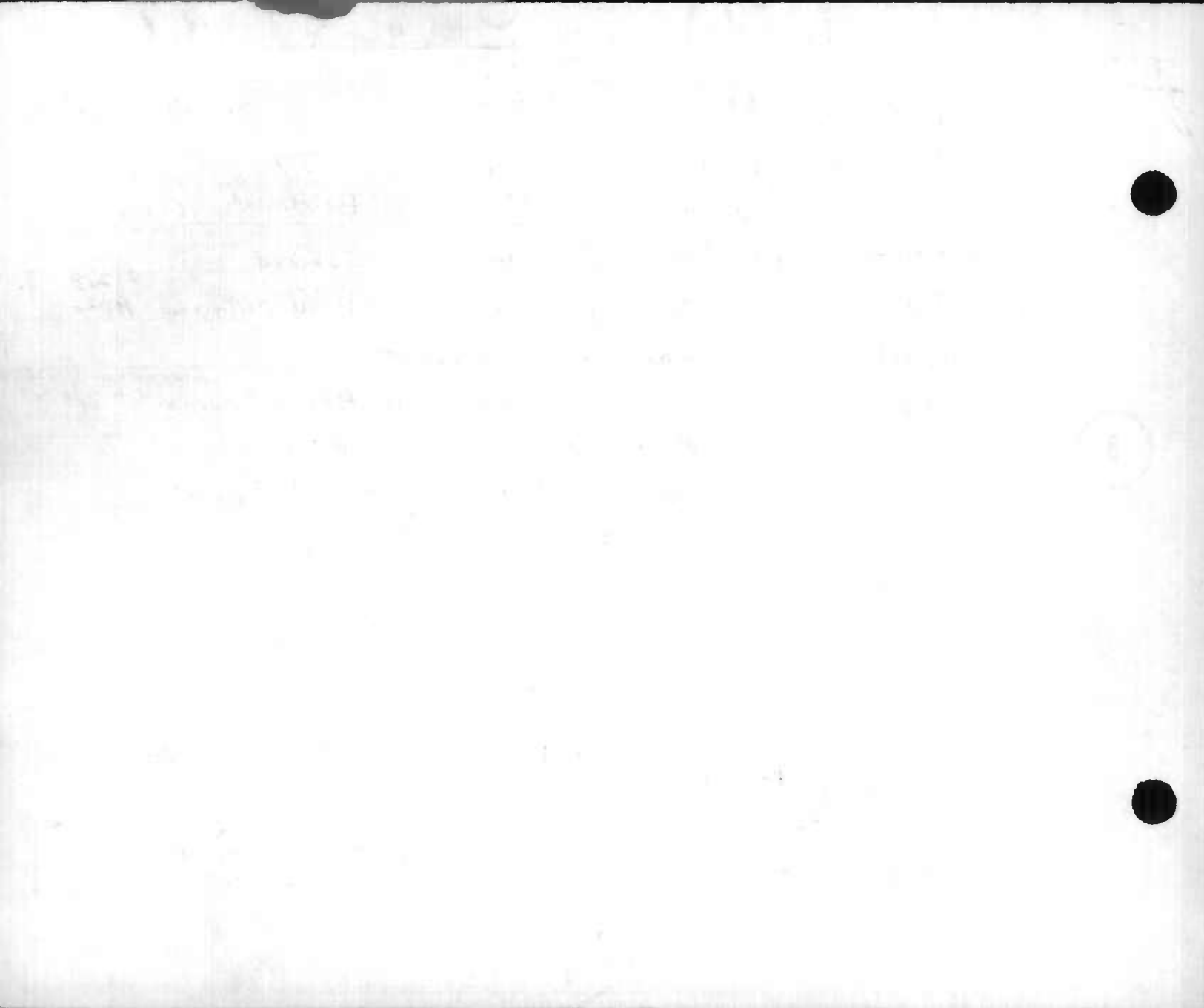
| | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Anna Phane | | FIR (ANAPHENE) | | MIDDLE | | LAST HORNE | | 2a. DATE OF DEATH MONTH 01 DAY 10 YEAR 1986 | | 2b. HOUR 155 AM | |
| 3. SEX Female | | 4. RACE black | | 5. DATE OF BIRTH MONTH 5 DAY 18 YEAR 08 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. STATE Md | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 1504 Cliftview Ave 21213 | | | |
| 14. FATHER'S NAME FIRST Edward MIDDLE LAST Lassane | | 15. MOTHER'S MAIDEN NAME FIRST Harriett MIDDLE LAST | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Laura Layton | | ADDRESS Alexandria Va 22314 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) End stage Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a ① Cardiac dysrhythmia ② RENAL failure | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR (AM) 155 MONTH 01 DAY 01 YEAR 1986 P.M. | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/19/85 to 01/01/86 that (I) (we) last saw the deceased alive on 02/31/85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE mdnone | | DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 01/01/86 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. ELNOUR | | 22e. ADDRESS 113 N. ROCK GLEN Road, Baltimore, MD, 21229 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/4/86 | | 23c. NAME OF CEMETERY OR CREMATORY Eastview Cemetery | | 23d. LOCATION CITY OR TOWN Baltimore COUNTY STATE Md | | | | | |
| 24. FUNERAL DIRECTOR William C. March F/H West 4300 Wabash Avenue | | 25a. DATE RECEIVED BY REGISTRAR JAN 7 1986 | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be placed for use in the burial-transit permit. Then please remove cardholders. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



031145

Item part #2 3/21/86 mth F#613
 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01178

FOR
 STATE
 REGISTRAR

REG. NO.

| | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|--|--|---|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST Frederick | | | MIDDLE Horne | | | LAST Horne | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR | | | 2b. HOUR | | | | | |
| 3. SEX M | | | 4. RACE B | | | 5. DATE OF BIRTH MONTH DAY YEAR 12 5 22 | | | 6. AGE (IN YEARS) LAST BIRTHDAY 63 YRS. | | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1/ 25/19 86 | | | 2d. HOUR 3:25 P | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hospital | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| 13a. STATE MARYLAND | | | | | | | | | 13b. COUNTY | | | 13c. CITY OR TOWN BALTIMORE | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS 2801 E. CHASE STREET 21213 | | |
| 14. FATHER'S NAME UNKNOWN | | | | | | | | | 15. MOTHER'S MAIDEN NAME ETHEL DIGGS | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES | | | (IF YES, GIVE WAR OR DATES) | | | 16b. SOCIAL SECURITY NO. 238-28-1134 | | | 17. INFORMANT FREDERICK THOMPSON P.O. BOX 17034 ADDRESS BALTO. MD. 21203 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>CHRONIC</u> <u>Acute Schizophrenia</u> | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | | | | | | | | | DATE SIGNED 1/26/86 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. | | | ADDRESS 111 Penn St. | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL BURIAL | | | 23b. DATE 1-30-86 | | | 23c. NAME OF CEMETERY OR CREMATORY GARRISON FOREST | | | 23d. LOCATION CITY OR TOWN COUNTY STATE OWING MILLS MARYLAND | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME WM.C.MARCH F/H INC. | | | | | | | | | | | | ADDRESS 1101 E. NORTH AVE. | | | 25a. DATE REC'D. BY REGISTRAR JAN 29 1986 | | | 25b. REGISTRAR'S SIGNATURE | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP
 DHMH - 17
 (VR A15 ME (5))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

20% COLIC + 12%
DINO



100% COTTON

030053

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01179

REG. NO.

| | | | | | | | | |
|---|--|---|---|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Charlotte Horris | | | 2a. DATE OF DEATH MONTH DAY YEAR 01-24-86 | | | 2b. HOUR M | | |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR July 6, 1924 | | 6. AGE (IN YEARS LAST BIRTHDAY) 8 61 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia | | 7b. CITIZEN OF WHAT COUNTRY? United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3823 Fourth Ave. 21226 | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | |
| 13a. STATE MD | | | | 13b. COUNTY City | | 13c. CITY OR TOWN Balto. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST (Unknown) | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (Unknown) | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- | | 17. INFORMANT John Horris | | ADDRESS Same as # 13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>metastatic renal cell carcinoma to lung and left pleural space</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>lung and left pleural space</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos. | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>October</i> 19 <i>85</i> , to <i>January</i> 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>January 23</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE <i>Aron Berkman</i> | | DEGREE MD | | ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/25/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Aron Berkman | | | | 22e. ADDRESS 3001 S. Hanover St. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Jan. 27, '86 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore A.A. MD | | |
| 24. FUNERAL DIRECTOR NAME McCully Funeral Home Balto., MD 21225 | | | | 25a. DATE REC'D. BY REGISTRAR JAN 28 1986 | | 25b. REGISTRAR'S SIGNATURE <i>Sarah Davidson-Randall</i> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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8 1/2 x 11 1/2 in. (215 x 292 mm)
100% cotton

2062



JAN 28 1988

027054

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | |
|---|--|---|---|---|
| DECEASED NAME (TYPE OR PRINT) Daniel Payne Horseman, Sr. <i>Danny Payne Horseman</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR 81 21 86 2 P.M. | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 2 7 54 | 6. AGE (IN YEARS LAST BIRTHDAY) 31 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore City | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Maryland Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Physician | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Maryland | | 13b. COUNTY Wicomico | 13c. CITY OR TOWN Salisbury | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME First Middle Last Woodrow Clarence Horseman | | 15. MOTHER'S MAIDEN NAME First Middle Last Anna Elizabeth Jester | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 214-60-8947 | | 17. INFORMANT Mrs. Anna H. Ent (Mother) 111 Lee Street, Salisbury, Maryland 21801 |

18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) INTRACRANIAL HYPERTENSION

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) SUBARACHNOID HEMORRHAGE

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

| | | | |
|--|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22. I certify that (a) this hospital attended the deceased from <u>January 24, 1986</u> to <u>January 21, 1986</u> , that (b) we last saw the deceased alive on <u>January 24, 1986</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not see the body after death) | | | |
| 22b. SIGNATURE <i>Robert W. Mudda</i> | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED 1/21/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT W. MUDDA | | 22e. ADDRESS 22 S. Greene St. Baltimore MD 21201 | |

| | | | |
|--|------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (PRECISE) Burial | 23b. DATE 1/24/1986 | 23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Pk | 23d. LOCATION (CITY OR TOWN) COUNTY STATE Salisbury, Wicomico, Maryland |
| 24. FUNERAL DIRECTOR NAME ADDRESS Holloway Funeral Home, P.A., Salisbury, Maryland | | 25a. DATE REC'D. BY REGISTRAR JAN 23 1986 | 25b. REGISTRAR'S SIGNATURE <i>John W. Mudda</i> |

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020259

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | |
|---|--|--|---|--|-------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) TAYLOR Caldwell HORTON | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 9, 1986 | | 2b. HOUR 10:35 A.M. | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR September 2, 1985 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 4 MONTHS 7 DAYS | | 7. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 9b. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY | | 9c. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STREET ADDRESS / ZIP CODE 9108 Cascus Drive - 22003 | | 13b. STREET ADDRESS / ZIP CODE 9108 Cascus Drive - 22003 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Craig Taylor Horton | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kathleen Waters | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Parents - 9108 Cascus Drive, Annandale, Va. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) HYPOTENSION DUE TO, OR AS A CONSEQUENCE OF (c) YEAST SEPSIS | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | |
| 19a. DATE OF OPERATION 12/20/85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Pulmonary artery banding for Rt → Lt shunt | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2) None | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/04 , 19 85 , to 1/9 , 19 86 , that (I) (we) last saw the deceased alive on 1/9 , 19 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | |
| 22b. SIGNATURE Barbara True Feltmo | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/9/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARBARA TRUE FELTMO | | 22e. ADDRESS DEPT. PEDIATRICS - JOHNS HOPKINS HOSPITAL | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/13/86 | | 23c. NAME OF CEMETERY OR CREMATORY Fairfax Memorial Park | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Fairfax Fairfax Va. | | 24. FUNERAL DIRECTOR NAME Malcolm O. Haynes | | 25a. DATE REC'D. BY REGISTRAR JAN 16 1986 | | |
| 25b. REGISTRAR'S SIGNATURE | | 25c. REGISTRAR'S SIGNATURE | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed by a physician who has attended the deceased within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP
DHMH - 16-60M 7/84
(VRA 15, 4)

DEMAINE F. H.
ALEXANDRIA, VA

JAN 16 1986

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100% COTTON FIBER

100% COTTON FIBER

MADE IN U.S.A.



036178

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 1 1 8 2

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|---|--|--------------------|
| 1. DECEASED NAME (TYPE OR PRINT) SHEILA M HOUCK | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 24 86 | | 2b. HOUR 2205 M |
| 3. SEX F | 4. RACE W | 5. DATE OF BIRTH MONTH DAY YEAR 8 24 56 | 6. AGE (IN YEARS LAST BIRTHDAY) 29 YRS. | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 8. BIRTHPLACE STATE OR FOREIGN PA | 9b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH BALT. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV. OF MD. | 12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) WAITRESS | 12b. KIND OF BUSINESS OR INDUSTRY PIZZA HUT | | |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE PA. 13b. COUNTY LANCASTER 13c. CITY OR TOWN NEW HOLLAND | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 505 E. MAIN ST. New Holland, PA. 17557 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JAMES W. HOUCK | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET L. KLINGER | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 184-88-1352 | 17. INFORMANT ADDRESS MARGARET L. WINEGARDNER 505 EAST MAIN ST. NEW HOLLAND, PA. | | | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Lymphoblastic Leukemia</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 16 mos |
|--|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

| | | | | |
|--|--|--|--|---|
| 19a. DATE OF OPERATION <u>Hepatitis</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/24</u> 19 <u>86</u> , to <u>1/24</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>1/24</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE <u>Angela Corbin</u> | DEGREE MD | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED 1/24/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANGELA CORBIN | | 22e. ADDRESS UNIVERSITY OF MARYLAND HOSP. | | |

| | | | |
|--|----------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE 1-29-86 | 23c. NAME OF CEMETERY OR CREMATORY STRASBURG MENNONITE CEMETERY | 23d. LOCATION CITY OR TOWN COUNTY STATE STRASBURG TWP. LANCASTER PA. |
| 24. FUNERAL DIRECTOR NAME GUNDAL FUNERAL HOME | | 24b. ADDRESS 415 N. DUKE ST. LANCASTER PA | 25a. DATE REC'D. BY REGISTRAR JAN 30 1986 |
| 25b. REGISTRAR'S SIGNATURE Julia Davidson | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other terminal event, if medical examiner is notified.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | |
|---|--|--|--|---|--------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET E. HOUSTON | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 3, 1986 | | 2b. HOUR 2:16 M | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 10 1 1897 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS. | | 7. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARried <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia | | 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Domestic | | 13. STREET ADDRESS / ZIP CODE 127 Oakwood Estates 25560 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Phillip Holz | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Scharf | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No ----- | | |
| 17. INFORMANT ADDRESS Scott Depo, West Virginia | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acidosis, Hypotension</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Sepsis</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hrs 1 day | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>CVA, HTKR</u> | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/3</u> , 19 <u>86</u> , to <u>1/3</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>1/3</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE <u>V Chang</u> | | DEGREE | | 22c. DATE SIGNED <u>1/3/86</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>V Chang</u> | | 22e. ADDRESS <u>Johns Hopkins Hospital</u> | | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-6-86 | | 23c. NAME OF CEMETERY OR CREMATORY Springhill Cemetery | | |
| 23d. LOCATION CITY OR TOWN COUNTY Charleston, Kanawha, West Virginia | | 24. FUNERAL DIRECTOR Marzullo Funeral Service | | 25a. DATE REC'D. BY REGISTRAR JAN 7 1986 | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201-2980
HOUSTON MARGARET E.
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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UNCLASSIFIED
DATE 11-11-01 BY 1043



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UNCLASSIFIED
DATE 11-11-01 BY 1043

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FOR
1. STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 1 1 8 4
REG. NO.

| | | | | | | |
|--|--|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) MARY ELLEN HOUSTON | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 2, 1986 | | 2b. HOUR P 4:30 M | |
| 3. SEX F | 4. RACE B | 5. DATE OF BIRTH MONTH DAY YEAR 8 6 36 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 49 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MARYLAND | | | 13b. COUNTY BALTIMORE | 13c. CITY OR TOWN BALTIMORE | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM DAN BROWN | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH STERN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 213-32-1178 | | 17. INFORMANT ADDRESS ELIZABETH BROWN 2128 WOLFE STREET | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>laryngeal carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>one week</u> <u>9 months</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Renal failure, hepatic insufficiency</u> | | | | | | |
| 19a. DATE OF OPERATION <u>April 1985</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>laryngeal carcinoma</u> | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/30</u> 19 <u>85</u> , to <u>1/2</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>1/2</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE <u>Glen Meckler MD</u> | | DEGREE <u>MD</u> | | 22c. DATE SIGNED <u>1/2/86</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Glen Meckler MD</u> | | 22e. ADDRESS <u>Johns Hopkins Hospital</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 1-7-86 | | 23c. NAME OF CEMETERY OR CREMATORY BALTIMORE | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | | 23e. DATE REC'D. BY REGISTRAR JAN 6 1986 | | | | |
| 24. FUNERAL DIRECTOR NAME WM.C.MARCH F/H INC. | | 25a. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | | | | | | | |
|---|---------|--|--|---|--|---|--|--|--|--------------------------|--|-------|--|------|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| WALTER D. HOWARD Sr. | | | | | | | | 1-27-86 | | 19 | | | | | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | |
| male | black | 4 16 52 | | 34 YRS. | | | | | | 1-27-86 | | 19 | | | | 4:20P | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | MD | |
| Maryland | | U.S.A. | | WIDOWED | | DIVORCED | | Baltimore City | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Baltimore | | University Hospital | | N/A | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | |
| Maryland | | Baltimore | | Towson | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 46 Lycette Circle 21220 | | | | | | | | | |
| FATHER'S NAME | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME | | FIRST | | MIDDLE | | LAST | | | | | |
| Harold | | | | Collins | | Helen | | | | | | Lewis | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| NO | | 214-56-6105 | | Vanessa H0ward | | 7400 Fairbrook Rd. Apt. 3D | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) <u>Cardiomyopathy</u> | | DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | (b) | | DUE TO, OR AS A CONSEQUENCE OF | | (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | alcoholism | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: | | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | TITLE (SPECIFY) | | DATE SIGNED | | 1-28-86 | | | | | | | | | |
| ACTUAL SIGNATURE | | M.D. | | Assistant | | MEDICAL EXAMINER | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | Margarita A. Korell, M.D. | | ADDRESS | | 111 Penn Street | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| BURIAL | | 2/1/86 | | Arbutus Memorial Park | | Arbutus, Md. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| March Funeral Homes | | 1101 East North Avenue | | JAN 31 1986 | | Selia Davidson-Randall | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

POST OFFICE

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|--|--|---|--|--|---|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Edward A. Howe | | | 2a. DATE OF DEATH MONTH DAY YEAR January 2, 1986 | | 2b. HOUR 2:30 PM | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR March 19 1906 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 79 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY Davis Chemical | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Howard 13c. CITY OR TOWN Hanover | | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Thomas Howe | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Wilson | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | | | |
| 16b. SOCIAL SECURITY NO. 216 - 14-3637 | | 17. INFORMANT ADDRESS Marie S. Howe 6535 Loudon Ave. Hanover, Maryland 21076 | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ATRIAL FIBRILLATION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CHRONIC OBSTRUCTIVE PULMONARY DIS.</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>PNEUMONITIS (11/85)</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YEARS YEARS | |
| 19a. DATE OF OPERATION — | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>8/2</u> , 19 <u>84</u> , to <u>12/16</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>12/16</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>Soon Ja Kim, M.D.</u> | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/3/86 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Soon Ja Kim | | 22e. ADDRESS Main St. Elkridge, Maryland 21227 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Jan. 6, 86 | | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Md. 21227 | | | | |
| 24. FUNERAL DIRECTOR NAME Gary L. Kaufman | | | | ADDRESS 5695 Main St. Elkridge 21227 | | 25a. DATE REC'D. BY REGISTRAR JAN 6 1986 | | 25b. REGISTRAR'S SIGNATURE <u>John Davidson</u> | | |

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COTTON FIELD



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2002 JAN 8

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01187

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|---|--|---|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) THOMAS F. HOWE Jr. | | | 2a. DATE OF DEATH MONTH DAY YEAR 01 30 86 | | | 2b. HOUR 12:40 PM | | | | |
| 3. SEX M (Male) | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR 05 11 14 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS | | 6. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ILLINOIS | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD. | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WYMAN PARK HEALTH SYSTEM | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Captain | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Ret.) | | |
| 13a. STATE MD | | | 13b. COUNTY BALTO | | 13c. CITY OR TOWN BALTO | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 119 B CROSS KEYS RD, BALTIMORE 21210. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST THOMAS Francis HOWE, Sr. | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Barbara KOSLOW | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input checked="" type="checkbox"/> UNKNOWN <input type="checkbox"/> Yes 1935-68 U.S. Navy | | | 16b. SOCIAL SECURITY NO. 037-26-2073 | | 17. INFORMANT ADDRESS Peter Howe, (Son) Same as 13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>HEPATIC FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ALCOHOLIC CIRRHOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>GASTROINTESTINAL HEMORRHAGE, ASCITES, COAGULOPATHY, UREMIA.</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>01/24/86</u> 19 <u>86</u> to <u>01/30</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>01/30</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>Bien D. Nguyen MD</u> | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <u>01/30/86</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BIEN D. NGUYEN, MD | | | | | | 22e. ADDRESS 3100 WYMAN PARK DR BALTIMORE 21211 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | 23b. DATE 1/31/1986 | | 23c. NAME OF CEMETERY OR CREMATORY Green Mount Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR Walter Brooks Bradley Inc., Balto., Md. 21222 | | | | | | 25a. DATE REC'D. BY REGISTRAR FEB 03 1986 | | 25b. REGISTRAR'S SIGNATURE <u>Davidson-Randall</u> | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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LIBRARY
NOTES
ON
THE
CITY



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01188

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | |
|--|---|---|---|--|--|--|-----------------------------------|---|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| RICHARD CHARLES HOYT | | | 1 28 86 | | | 11:50PM | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | | | 7. IF UNDER 1 YEAR | | |
| Male | White | May 23, 1926 | 59 | | | MONTHS DAYS HOURS MIN. | | |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 8b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Turton, S.Dak. | USA | | Baltimore city MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | VAMC, Baltimore, Maryland 21218 | | | Systems Analyst | | | US-govt. Ret. | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE | | | | |
| Maryland | Harford | Bel Air | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 516 East Broadway 21014 | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| Earl Leonard Hoyt | | | Lillian Dorothea Thomas | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | |
| Yes | | | WWII | | | 21014 | | |
| | | | 543-12-3601 | | | Bette N. Hoyt, 516 East Broadway, Bel Air, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) MITRAL STENOSIS | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) RHEUMATIC HEART DISEASE | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| | | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JANUARY 16, 19 86 to JANUARY 28, 19 86, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on JANUARY 28, 19 86, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above (initials) (did not view the body after death) | | | | | | | | |
| 22b. SIGNATURE | | | | | | 22c. DATE SIGNED | | |
| FRANK KIM | | | | | | 1/29/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | |
| FRANK KIM | | | | | | VAMC, Baltimore, Maryland 21218 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| Cremation | | Feb. 1, 1986 | | R.A. Ferris Crematory | | W. Chester, Chester Pa. | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | | | |
| Howard K. McComas III, Abingdon, Md. 21009 | | | | FEB 03 1986 [Signature] | | | | |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and file them in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.



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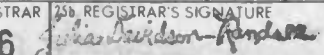
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|---|-------------------------|---|---|---|--|---|---|--|
| DECEASED NAME (TYPE OR PRINT) CHARLES Lee HUGGINS | | | 2b. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 30 1986 | | | 7d. HOUR M | | |
| 3. SEX male | 4. RACE black | 5. DATE OF BIRTH MONTH DAY YEAR 11 22 1934 | 6. AGE (IN YEARS) LAST BIRTHDAY YRS. 51 | IF UNDER 1 YR. MONTHS DAYS 0 0 | IF UNDER 24 HRS. HOURS MIN. 00 00 | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 31 1986 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2230 Linden Ave. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Decorator (Interior) | | 12b. KIND OF BUSINESS OR INDUSTRY Private |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2230 Linden Avenue Baltimore, Maryland 21217 |
| 14. FATHER'S NAME FIRST MIDDLE LAST Robert Lee Huggins Sr. | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Thelma Giam | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1956 - 1959 | | 17. INFORMANT 5047 Drywell Court, Columbia, Maryland Mr. & Mrs. Kenneth Brooks | | | 17b. ADDRESS 21045 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE  | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | | DATE SIGNED 2-1-86 | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | ADDRESS 111 Penn St., Balto., MD 21201 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 2/6/1986 | | 23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Veterans | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | |
| 24. FUNERAL HOME NAME ADDRESS NESTER & SONS FUNERAL HOME, INC. 2501 GWYNNS FALLS PKWY. BALTIMORE, MD. 21216 | | | | 25a. DATE REC'D. BY REGISTRAR FEB 06 1986 | | 25b. REGISTRAR'S SIGNATURE  | | |

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01190

REG. NO.

| | | | | | | | | | | |
|--|--|---|---|---|--|--|--|---|---|--|
| 4 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Agnes Hunter | | | 2a. DATE OF DEATH MONTH DAY YEAR 01 04. 86 | | 2b. HOUR 10 40A M | | | | | |
| 3. SEX Female | | 4 RACE black | | 5. DATE OF BIRTH MONTH DAY YEAR 6 18 19 | | 6 AGE (IN YEARS LAST BIRTHDAY) 66 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | |
| 10 CITY OR TOWN OF DEATH Balto | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md | | | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Plummer Mills | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Penny Sewell Mills | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 225-09-4907 | | 17. INFORMANT ADDRESS Ezra Hunter 2112 N. Rosedale St | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RNL and Gbase pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Resp failure DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12/26/85 12/26/85- | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Parkinsonism | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/26 19 85 , to 1/4 19 86 , that (I) (we) last saw the deceased alive on 1/4 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Donatun M. Naareem | | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/4/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) AMATUN M. NAAREEM | | | | 22e. ADDRESS 501 Dolphin St. B-48 MD 21217 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/10/86 | | 23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Vet | | 23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills Md | | | | |
| 24 FUNERAL DIRECTOR NAME William C. March F/H West | | | | ADDRESS 4300 Wabash Avenue | | 25a. DATE REC'D. BY REGISTRAR JAN 8 1986 | | 25b. REGISTRAR'S SIGNATURE John R. Anderson | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the coroner/examiner must be notified of one.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND | | | | 01191 | | | |
|--|--|--|--|---|--|--|--|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | CERTIFICATE OF DEATH | | | |
| FOR 1 - STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST <i>Rosanna</i> MIDDLE <i>Barnett</i> LAST <i>Husband</i> <i>(Roseanna) (Husbands)</i> | | | | 2a. DATE OF DEATH MONTH <i>1</i> DAY <i>5</i> YEAR <i>86</i> | | 2b. HOUR <i>9:38</i> M | |
| 3. SEX <i>Female</i> | | 4. RACE <i>black</i> | | 5. DATE OF BIRTH MONTH <i>4</i> DAY <i>8</i> YEAR <i>1913</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>72</i> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>N.C.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD. | |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Luthman Hospital</i> | | 12a. USUAL OCCUPATION (NAME OF WORK FOR MOST OF WORKING LIFE) <i>Disabled</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE <i>Md</i> | | | | 13b. COUNTY | | 13c. CITY OR TOWN <i>Baltimore</i> | |
| 14. FATHER'S NAME FIRST <i>Hampton</i> MIDDLE LAST <i>Barnett</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST <i>Alice</i> MIDDLE LAST <i>Heath</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i> | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <i>Leon Barnett 1501 Ellamont Street</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cervical arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <i>Left Cervical Injured</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11/18</i> 19 <i>85</i> to <i>1/5</i> 19 <i>86</i> that (I) (we) lost saw the deceased alive on <i>1/5</i> 19 <i>86</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>Edward A. Wolf</i> | | | | DEGREE <i>MD</i> | | 22c. DATE SIGNED <i>1/5</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Edward A. Wolf</i> | | | | 22e. ADDRESS <i>6408 BERRY AVE BALT., MD.</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>1/10/86</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>King Memorial Park</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Randallstown Md</i> | |
| 24. FUNERAL DIRECTOR NAME <i>William C. March F/H West</i> | | | | ADDRESS <i>4300 Wabash Avenue</i> | | 25a. DATE REC'D. BY REGISTRAR <i>JAN 10 1986</i> | |
| | | | | 25b. REGISTRAR'S SIGNATURE | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

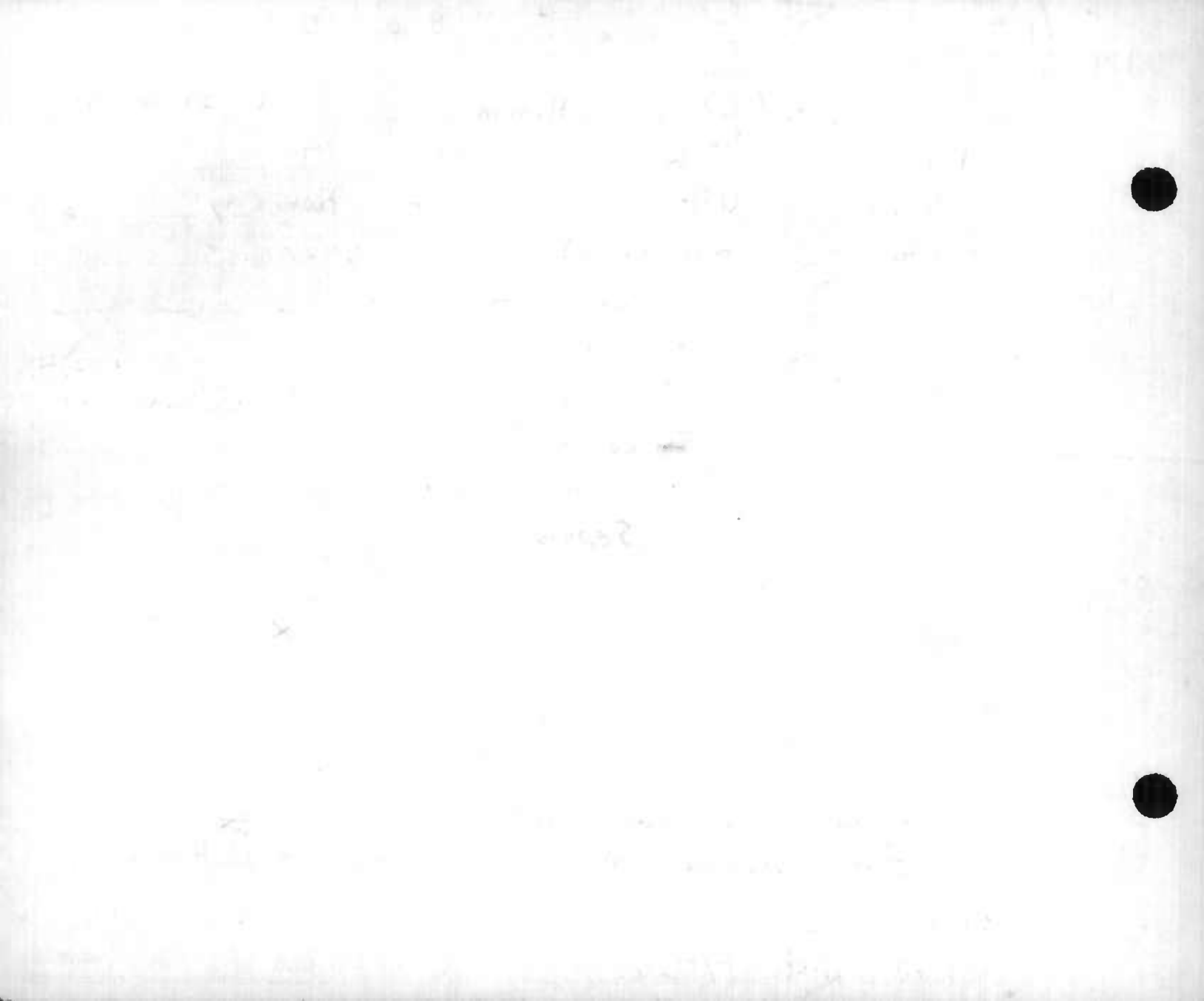
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

011928

| | | | |
|---|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | |
| FIRST MIDDLE LAST Daniel Hyman | | MONTH DAY YEAR 1 29 86 | |
| 3 SEX | | 2b. HOUR | |
| Male | | 4:00 P.M. | |
| 4 RACE | | 6 AGE (IN YEARS LAST BIRTHDAY) | |
| Black | | 79 YRS | |
| 5. DATE OF BIRTH | | IF UNDER 1 YEAR | |
| MONTH DAY YEAR 10 6 6 | | MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 9 BALTIMORE CITY OR COUNTY OF DEATH | |
| N.C. | | Balto, City MD. | |
| 7b. CITIZEN OF WHAT COUNTRY? | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| USA | | UNKNOWN | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 10 CITY OR TOWN OF DEATH | | | |
| Balto | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | |
| Sinai Hospital | | | |
| 12c. STREET ADDRESS / ZIP CODE | | | |
| 5100 Queensbury 21215 | | | |
| 13a. STREET ADDRESS / ZIP CODE | | | |
| 5100 Queensbury 21215 | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | |
| FIRST MIDDLE LAST Nathan Hyman | | FIRST MIDDLE LAST Caroline | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| NO | | 219-07-1267 | |
| 17. INFORMANT | | ADDRESS | |
| Lavinia Hyman | | 5411 Sherrell Rd. APT. D. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | |
| IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | |
| (b) <u>Cardiac Arrest</u> | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | |
| (c) <u>Sepsis</u> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | |
| | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | |
| 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | |
| | | HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | |
| AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION | | CITY OR TOWN COUNTY STATE | |
| STREET | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE | | DEGREE | |
| Eric Weiner | | MD | |
| 22c. DATE SIGNED | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | |
| Eric Weiner MD | | Sinai Hosp of Baltimore | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | |
| BURIAL | | 2-4-86 | |
| 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Mount Auburn | | CITY OR TOWN COUNTY STATE Baltimore Maryland | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | |
| NAME M. C. March F/H INC. ADDRESS 1101 E. North Ave. | | FEB 04 1986 | |
| 25b. REGISTRAR'S SIGNATURE | | | |
| J. H. [Signature] | | | |



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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01193

REG. NO.

| | | | | | | | | |
|---|---------|----------------------------|---|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| FIRST MIDDLE LAST Mary A. Hyman | | | MONTH DAY YEAR 11/16/86 | | | 4:35 P.M. | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | | | 7. IF UNDER 1 YEAR | | |
| Female | White | MONTH DAY YEAR 7-5-1918 | 67 YRS. | | | IF UNDER 24 HRS. | | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7c. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| Balto., MD | | | USA | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | |
| Balto., City | | | Union Memorial Hospital | | | Cafeteria Mgr. | | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | 13a. STREET ADDRESS / ZIP CODE | | | 13b. SCHOOL Bld. | | |
| School Bld. | | | 5925 Kavon Ave., Balto. 21206 | | | Balto. 21206 | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | |
| FIRST MIDDLE LAST Henry Klein | | | FIRST MIDDLE LAST Alice Kelly | | | 16b. SOCIAL SECURITY NO. 220-38-5030 | | |
| 17. INFORMANT | | | 18. ADDRESS | | | 19. DATE OF OPERATION | | |
| Eugene C. Hyman, 5925 Kavon Ave. Balto. 21206 | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) Pulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Chronic obstructive Pulmonary Disease +(c) Pulmonary Hypertension

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (this hospital) attended the deceased from <u>11/30/85</u> to <u>1/16/86</u> , that (we) last saw the deceased alive on <u>1/16/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death. | | 22b. SIGNATURE <u>L. M. Gloth</u> | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/16/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) F M Gloth | | 22e. ADDRESS | | | | | |

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| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | 1-18-86 | | Gardens of Faith | | Balto. Balto., MD | |
| 24. FUNERAL DIRECTOR John C. Miller, Inc., 6415 Belair Rd. 21206 | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| | | | | JAN 21 1986 | | <u>John C. Miller</u> | |

11150

006009

STATE OF MARYLAND 8 6
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01194

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|--|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) LILLIAN MAY IMHOFF | | | 2a. DATE OF DEATH MONTH DAY YEAR JAN 1 86 | | | 2b. HOUR 1132 M | |
| 3 SEX FEMALE | | 4 RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR MAR 13 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY — | |
| 13a. STATE MD | | | | 13b. COUNTY BALT. | | 13c. CITY OR TOWN BALT. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM IMHOFF | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY LOWMAN. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 213 20 3644 | | 17. INFORMANT PT. CHART. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ABDOMINAL DISTENTION. DUE TO, OR AS A CONSEQUENCE OF (c) PANCREATIC CANCER. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: — | | | | | | | |
| 19a. DATE OF OPERATION — | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR — — — 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) — | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) — | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE — — — — — | | | |
| 22a. I certify that (1) (this hospital attended the deceased from SEP 22 19 85 to 1 JAN 19 86), that (1) (we last saw the deceased alive on 1 JAN 19 86), and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE Dillon, MD | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1 JAN 86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dillon, MD | | | | 22e. ADDRESS 6mm 22 So Green St BAL MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Jan. 6, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn | | 23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn, Balto. Co., Md. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212 | | | | 25a. DATE REC'D. BY REGISTRAR JAN 2 1986 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE J. A. Davidson | | | |

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MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate should be filed with the State Dept. of Health and Mental Hygiene.

СВЯТОСЛАВ



ПРЕД ПОТОД. 2002

ДВОД. МАКТАЛИН

016095

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01195

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|--|--|--|---|---|-----------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ARTHUR D INMAN | | | 2a. DATE OF DEATH MONTH DAY YEAR JAN 12 1986 | | 2b. HOUR 455 A.M. | | |
| 3. SEX MALE | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR May 15, 1922 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 63 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer | | 12b. KIND OF BUSINESS OR INDUSTRY Communication | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Lutherville | |
| 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13e. STREET ADDRESS / ZIP CODE 6 Nightingale Way 21093 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Glendon Inman | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna Honeywell | | 16. NIGHTINGALE WAY 6 Nightingale Way | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII | | 17. INFORMANT DR Miriam M. Inman | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PULMONARY EMBOLISM DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF THE PROSTATE DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. that (I) (we) last saw the deceased alive on _____, 19_____. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE B. J. Hart | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/12/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARBARA J. 'C HART | | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/15/86 | | 23c. NAME OF CEMETERY OR CREMATORY Sunnyside Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Wyoming Co., Pennsylvania | |
| 24. FUNERAL DIRECTOR NAME ADDRESS William E. Johnson 8521 Loch Raven Bl. | | | | 25a. DATE RECD. BY REGISTRAR JAN 13 1986 | | 25b. REGISTRAR'S SIGNATURE | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

RECEIVED



021020

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01196

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) Joseph L. Ipsaro | | | 2a. DATE OF DEATH MONTH DAY YEAR Jan 16 1986 | | 2b. HOUR M |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR March 20 1930 | 6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Analyst-Beth. Steel | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME Joseph MIDDLE Ipsaro LAST | | | 15. MOTHER'S MAIDEN NAME Rose MIDDLE Schmidt LAST | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) Korea 212-26-5708 | 17. INFORMANT ADDRESS Mrs. Esther C. Ipsaro Same as #13E | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ASHCVD - Acute MI</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/3/86</u> 19 <u>86</u> to <u>1/16/86</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>1/15/86</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Donald W. Mintzer</u> | | DEGREE MD | | 22c. DATE SIGNED 1/16/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald W. Mintzer MD | | 22e. ADDRESS 3009 Evergreen Avenue Baltimore, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 1-18-86 | 23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | |
| 24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. | | 25a. DATE REC'D. BY REGISTRAR JAN 17 1986 | | 25b. REGISTRAR'S SIGNATURE <u>W. W. Anderson</u> | |

MEDICAL CERTIFICATION

29

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

030130



009173

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) Ella M. Jackson | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 3 86 | | 2b. HOUR 1:30 PM |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 9-9-1903 | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS. | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto., MD | 8b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerical Work | 12b. KIND OF BUSINESS OR INDUSTRY Fulton Grand Laundry | |
| 13a. STATE MD | | 13b. COUNTY | 13c. CITY OR TOWN Balto. City | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 3214 Elmley Ave., Balto., 21213 |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Marks | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-30-9742 | 17. INFORMANT ADDRESS Charles L. Jackson, 123 Dublin Drive | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Equal stroke renal failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bladder Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/1/85</u> 19 <u>85</u> , to <u>1/3/86</u> 19 <u>86</u> that (I) (we) last saw the deceased alive on <u>1/3</u> 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If not true, do not sign the body after death.) | | | | | |
| 22b. SIGNATURE <u>Robert Vissing</u> | | DEGREE MD | | 22c. DATE SIGNED 1/3/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Vissing, M.D. | | 22e. ADDRESS Union Memorial Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 1-6-86 | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. MD | | |
| 24. FUNERAL DIRECTOR Name John G. Miller, Inc., 6415 Belair Rd. 21206 | | | 25a. DATE REC'D. BY REGISTRAR JAN 7 1986 | 25b. REGISTRAR'S SIGNATURE <u>John Davidson-Rendell</u> | |

BP

6-1000

RECEIVED

WALTON



023098

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY CHARGE IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|---|---------|------------------|--|------------------------|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR | | |
| FIRST MIDDLE LAST Greer Michel Jackson | | | XX MONTH DAY YEAR 1-20 19 86 | | | M 6:31 a. | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE | 7. IF UNDER 1 YR. | 8. IF UNDER 24 HRS. | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| F | W | June 7, 1945 | 40 YRS. | MONTHS DAYS HOURS MIN. | MONTHS DAYS HOURS MIN. | Baltimore City, MD | | |
| 10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | |
| MD | | | USA | | | Executive R.E. | | |
| 13. CITY OR TOWN OF DEATH | | | 14. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 15. MOTHER'S MAIDEN NAME | | |
| Baltimore | | | University Hospital - STU | | | Mary Ellen Hermetet | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | |
| No | | | 213 46 1217 | | | Robert E. Michel, Jr., Same | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY: | | | | | | | | |
| IMMEDIATE CAUSE (a) Multiple Injuries | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| (b) | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| (c) | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | |
| | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | HOURS MONTH DAY YEAR 3:20 PM 1-18 19 86 | | struck by auto while standing on porch | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> ? | | | porch | | Stevenson Rd. north of Hillside Rd., Balto. Co., Maryland | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE | | | TITLE (SPECIFY) | | | DATE SIGNED | | |
| Dennis F. Smyth, M.D. | | | Assistant | | | 1-20-86 | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | ADDRESS | | | | | |
| Dennis F. Smyth, M.D. | | | 111 Penn St., Balto., Md. 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Burial | | | 1/22/86 | | Ellicott Graveyard | | Ellicott City, MD | |
| 24. FUNERAL DIRECTOR NAME | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| Henry W. Jenkins & Sons Co. | | | JAN 21 1986 | | | Dennis F. Smyth | | |
| 4905 York Road Balto., MD 21212 | | | | | | | | |

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

033079

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June 7, 1941

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F. E.

Executive

1941

W. B. Chetwick Co., 1117

Belts, Cowin & White

1941

1941

Ellen

Mary

Michael

E.

Robert

1941

1941

1941



1941

Ellen

1941

1941

Henry A. Johnson Co.

1941

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return certificate, page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

013079

1- FOR
STATE
REGISTRARSTATE OF MARYLAND 8 6
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|---|--|---|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) HOWARD JACKSON | | | 2a. DATE OF DEATH MONTH DAY YEAR January 6, 1986 | | | 2b. HOUR M | | | | |
| 3. SEX MALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR Apr. 27, 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2707 EAST FEDERAL ST. 21213 | | | | 12a. USUAL OCCUPATION (TYPE OF PROFESSION OR WORKING LIFE) RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE MARYLAND | | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 2707 E. FEDERAL STREET 21213 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST HOWARD JACKSON | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE FRANKLIN | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A | | 17. INFORMANT ADDRESS DARNELLA T. JACKSON 2707 E. Federal St. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per item 18a, 18b, and 18c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardio pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) carcinoma of colon metastases to brain DUE TO, OR AS A CONSEQUENCE OF (c) TO BRAIN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 11a | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 11/02 19 82 to 01/5 19 86 , that (I) (we) last saw the deceased alive on 01/04 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 23a. SIGNATURE Robert J. Williams | | | DEGREE M.D. | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 23c. DATE SIGNED 1/6/86 | | |
| 23b. PHYSICIAN'S NAME (TYPE OR PRINT) Robert J. Williams | | | 23d. ADDRESS 4605 EDMONDSON AVE BALTIMORE | | | | | | | |
| 23e. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23f. DATE 1/11/86 | | 23g. NAME OF CEMETERY OR CREMATORY Baltimore Cemetary | | 23h. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Leroy O. Dyett | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 9 1986 | | | | |
| ADDRESS 4600 Liberty Hgts. Ave. | | | | | | 25b. REGISTRAR'S SIGNATURE John D. ... | | | | |

FOX COTTON FIBER

028098

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE T LAST JACKSON | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 18 86 | | 2b. HOUR 11:00 AM |
| 3. SEX Female | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 4 10 1892 | | 6. AGE (IN YEARS LAST BIRTHDAY) 93 | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Forest Haven Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic | 12b. KIND OF BUSINESS OR INDUSTRY Pvt Family | |
| 13a. STATE Maryland | | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE Ave Baltimore, Md. 21201 |
| 14. FATHER'S NAME FIRST Charles MIDDLE LAST JACKSON | | 15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Rebecca LAST Quickley | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no | | 16b. SOCIAL SECURITY NO. 219-22-9296 A | | 17. INFORMANT ADDRESS Romana Gaskins 3113 Mondawmin Avenue Baltimore, Md. 21216 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a POTS DISEASE, DEGENERATIVE JOINT DISEASE | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Tasneem Lakhami | | DEGREE MD) ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/21/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) TASNEEM LAKHAM | | 22e. ADDRESS 7220 PARK HEIGHTS AVE, BALD MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 1/22/1986 | 23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md. | 23e. ZIP CODE 21208 |
| 24. FUNERAL DIRECTOR Nutter & Sons Funeral Home, Inc. 2501 Gwynns Falls Parkway Baltimore, Md. 21216 | | | 25. DATE REC'D. BY REGISTRAR JAN 24 1986 | | |
| 26. REGISTRAR'S SIGNATURE [Signature] | | | 27. REGISTRAR'S SIGNATURE [Signature] | | |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

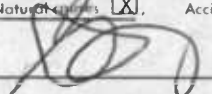
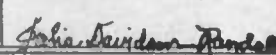
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | | | |
|--|--|------------------|------------------|--|--|---|--|---|-----------------|--|--|---|--|---|-----------------------|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST William | | | MIDDLE F. | | | LAST Jackson | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1/23/ 1986 | | | 2b. HOUR M | | | | |
| 3. SEX MALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR JAN. 3, 1923 | | 6. AGE (IN YEARS) LAST BIRTHDAY 63 YRS. | | 7. IF UNDER 1 YR. MONTHS DAYS | | 8. IF UNDER 24 HRS. HOURS MIN | | 2c. DATE PRONOUNCED DEAD 1/23/ 1986 | | | 2d. HOUR 11:17 P M | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA | | | | 7b. CITIZEN OF WHAT COUNTRY? US of A | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) GROOM | | | | 12b. KIND OF BUSINESS OR INDUSTRY RACE TRACK | | | | | |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | | | | | | | | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3715 ARCADIA AVE. 21215 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST RICHARD R JACKSON | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY LEE | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES | | | | (IF YES, GIVE WAR OR DATES) KOREAN | | 16b. SOCIAL SECURITY NO. 230 24 0743 | | 17. INFORMANT ADDRESS MRS. MARY E. JACKSON 21215 3715 ARCADIA AVE. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>Arteriosclerotic Cardiovascular Disease</u> (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY) M.D. Assistant | | | | MEDICAL EXAMINER | | | | DATE SIGNED 1/24/86 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. | | | | ADDRESS 111 Penn St. | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 1/29/86 | | 23c. NAME OF CEMETERY OR CREMATORY ARBUTHNOT MEMORIAL PARK | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE (BALTO.) MD. | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME LEWIS T. GWYNN | | | | ADDRESS 4517 PARK HEIGHTS AVENUE | | | | 25a. DATE REC'D. BY REGISTRAR JAN 28 1986 | | | | 25b. REGISTRAR'S SIGNATURE  | | | | | | | |

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | | | | | | |
|--|--|---------------------|--|--|--|--|--|---|--|--|--|---|--|---|--|---|--|
| 1- DECEASED NAME (TYPE OR PRINT) Walter Julius James | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 1 DAY 9 YEAR 1986 | | 2b. HOUR M | | 2c. DATE PRONOUNCED DEAD 1 9 1986 | | 2d. HOUR 8:31A | | | | | |
| 3 SEX Male | | 4 RACE Black | | 5 DATE OF BIRTH MONTH 4 DAY 25 YEAR 44 | | 6 AGE (IN YEARS) (LAST BIRTHDAY) 41 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD 1 9 1986 | | 7d. HOUR M | | | | | |
| 8 BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md. | | | | 9a. CITIZEN OF WHAT COUNTRY? U.S.A | | | | 9b. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9c. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, | | 9d. MD. | | | |
| 10 CITY OR TOWN OF DEATH Baltimore | | | | 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 400 Blk. Robert Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | | | | 12b. KIND OF BUSINESS OR INDUSTRY ---- | | | | | |
| 13a. STATE Maryland | | | | 13b. COUNTY | | 13c. CITY OR TOWN City | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 512 Robert St. 21217 | | | | 13f. BALTIMORE, MD. | | | |
| 14 FATHER'S NAME FIRST Unknown MIDDLE LAST | | | | | | 15 MOTHER'S MAIDEN NAME FIRST Doris MIDDLE James LAST James | | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 217-38-6373 | | 17. INFORMANT ADDRESS Baltimore, Md. Alfred Owens 1522 May Ct. 21231 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Narcoetism DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Dennis F. Smyth | | | | TITLE (SPECIFY) Assistant | | | | DATE SIGNED 1/9/86 | | | | M.D. Assistant | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. | | | | ADDRESS 111 Penn St. Balto.MD. | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 1/15/86 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | | | | | | |
| 24 FUNERAL DIRECTOR NAME William C. Brown | | | | | | ADDRESS 1206-08 W. North ave. 21217 | | | | 25a. DATE REC'D. BY REGISTRAR JAN 13 1986 | | | | 25b. REGISTRAR'S SIGNATURE | | | |

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|---|--|--|--|--|---|---|---|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HELEN M. JARRATT | | | 2a. DATE OF DEATH MONTH DAY YEAR January 3, 1986 | | 2b. HOUR 8:51A M | | | | | | |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 22, 1921 | | 6 AGE (IN YEARS LAST BIRTHDAY) 64 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 100 W. University Parkway | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Registrar | | 12b. KIND OF BUSINESS OR INDUSTRY JHU | | | |
| 13a. STATE MD | | | | | 13b. COUNTY | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST John R. Montgomery | | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary C. Frick | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | | | 16b. SOCIAL SECURITY NO. 155 18 5580 | | 17 INFORMANT ADDRESS Carlyle L. Barton, Balto., MD | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Breast Carcinoma | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from above (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) (11) (12) (13) (14) (15) (16) (17) (18) (19) (20) (21) (22) (23) (24) (25) (26) (27) (28) (29) (30) (31) (32) (33) (34) (35) (36) (37) (38) (39) (40) (41) (42) (43) (44) (45) (46) (47) (48) (49) (50) (51) (52) (53) (54) (55) (56) (57) (58) (59) (60) (61) (62) (63) (64) (65) (66) (67) (68) (69) (70) (71) (72) (73) (74) (75) (76) (77) (78) (79) (80) (81) (82) (83) (84) (85) (86) (87) (88) (89) (90) (91) (92) (93) (94) (95) (96) (97) (98) (99) (100) (101) (102) (103) (104) (105) (106) (107) (108) (109) (110) (111) (112) (113) (114) (115) (116) (117) (118) (119) (120) (121) (122) (123) (124) (125) (126) (127) (128) (129) (130) (131) (132) (133) (134) (135) (136) (137) (138) (139) (140) (141) (142) (143) (144) (145) (146) (147) (148) (149) (150) (151) (152) (153) (154) (155) (156) (157) (158) (159) (160) (161) (162) (163) (164) (165) (166) (167) (168) (169) (170) (171) (172) (173) 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HERN M. J. FRATT

January 1, 1961

White Oct. 22, 1961

New Jersey USA Baltimore, MD

Baltimore 100 W. University Parkway

Balt.

100 W. University Parkway

Monday, January 2, 1961

No 125 18 5500 Davis, Barton, Baltimore, MD

x

Dr. David M. Fagan, MD

100 W. University Parkway, Baltimore, MD

Washington 1 mile from Baltimore

Henry W. Allen, Jr., MD, PhD

New York, NY 10017

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STATE OF MARYLAND 8 6
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

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|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE AND PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| Russell J. Jeffries | | | | 1/21/86 | | 23 | | AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| M | | B | | 10/28/44 | | 41 | | MONTHS DAYS HOURS MIN. | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7c. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| MD | | USA | | | | Baltimore city MD | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NONE IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | Univ. Md Hosp. | | | | Bus | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS & ZIP CODE | |
| MD | | Baltimore | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1633 Gwynn Falls Pkwy 21212 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| Unknown | | Unknown | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES) | | 212-46-3602 | | Hosp. Char | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypotension/Arrhythmias</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myocarditis</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | 21d. INJURY OCCURRED | | | |
| | | HOUR A.M. MONTH DAY YEAR | | (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | |
| | | P.M. 19 | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | |
| | | | | | | 21f. LOCATION (STREET CITY OR TOWN COUNTY STATE) | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/20 19 86, to 1/21 19 86, that (we) (I) saw the deceased alive on 1/21 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | |
| M. Antos MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 1/21/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | |
| M. Antos MD | | | | Univ. Md. Hosp. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (IF OTHER, SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | 23e. STATE | |
| Burial | | 1/24/86 | | Garrison Heights | | Baltimore | | Maryland | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| NAME E. C. Phelps | | | | ADDRESS 1721-27 W. Mmms st | | JAN 27 1986 | | | |

MEDICAL CERTIFICATION

29

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

008167

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN COPIES OF YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4
25MBP
DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|-------------------------|--|---|---|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) CINDY Lou JENKINS | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 1 3 19 86 | | | | 2b. HOUR 7:40 | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 2 1 57 | 6. AGE (IN YEARS LAST BIRTHDAY) 28 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 3 19 86 | 2d. HOUR 7:40 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Balto. Gen. Hosp. (DOA) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cashier | | 12b. KIND OF BUSINESS OR INDUSTRY Dept Store | | |
| 13a. STATE Maryland | | | | 13b. CITY OR TOWN Baltimore | 13c. STREET ADDRESS 3612 Apt 1 Brooklyn Ave 21225 | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Benjamin W Smith Sr. | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hilda R. Long | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 216-78-7108 | | 17. INFORMANT North Tamiami Trail N. Ft Myers Fla Benjamin W. Smith Sr. 2557 Lot #8 33903 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Transection of aorta DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOURS MONTH DAY YEAR 6:40 M. 1-3- 19 86 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Passenger of motorcycle/auto collision. | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE E. Patapsco Ave. at 3rd St., Balto. City MD | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | DATE SIGNED 1-4-86 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | | ADDRESS 111 Penn St., Balto., MD 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 1/6/86 | | 23c. NAME OF CEMETERY OR CREMATORY Westview Memorial Park | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto Md | | |
| 24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hgwy Balto Md | | | | 25a. DATE REC'D. BY REGISTRAR JAN 6 1986 | | 25b. REGISTRAR'S SIGNATURE | | | |

7-1880

20% COTTON



Handwritten signature or mark.

007150

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01206

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Margaret I. Jenkins | | | 2a. DATE OF DEATH MONTH DAY YEAR 1-2-86 | | | 2b. HOUR 8:00 P.M. | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 3 7 18 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3318 Chestnut Avenue 21211 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress | |
| 13a. STATE Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Clyde Slonaker | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida (unknown) | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -- | | 17. INFORMANT ADDRESS Irvin Jenkins 3318 Chestnut Ave. 21211 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Pulmonary Disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>minutes</u> <u>years</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>myocardial infarction in preceding weeks</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 9</u> 19 <u>85</u> to <u>Dec 28</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>Dec 28</u> 19 <u>85</u> , and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (I) did not view the body after death, so state.) | | | | | | | |
| 22b. SIGNATURE <u>Theodore Kramer</u> | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1-3-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) THEODORE KRAMER | | 22e. ADDRESS 201 E. UNIV. PKWY UNION MEMORIAL HOSPITAL BALT. MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/6/86 | | 23c. NAME OF CEMETERY OR CREMATORY Crest Lawn Mem. Gdns. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | |
| 24. FUNERAL DIRECTOR NAME A. Alan Seitz, Jr. 3615-19 Chestnut Ave. 21211 | | | | 25a. DATE REC'D. BY REGISTRAR JAN 3 1986 | | 25b. REGISTRAR'S SIGNATURE <u>Wanda W. Hordell</u> | |

BP
DHMH - 16 50M 4/83
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0071700

08-3-1

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034008

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01207

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|---|--|--|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) MARLENE M. JETER | | | 2a. DATE OF DEATH MONTH DAY YEAR 01 28 86 | | | 2b. HOUR 505 PM | | | | | |
| 3. SEX F | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 03 22 33 | | 6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT BY SUCH FACILITY, GIVE STREET ADDRESS) S. Fair Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE md | | | 13b. COUNTY | | 13c. CITY OR TOWN BALTO | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 4543 The Strand 21215 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Talbot Davenport | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amanda M. Tucker | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 415-33-9506 | | 17. INFORMANT ADDRESS Cheryl L. Jeter 2410 Wellbridge Dr. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute intracerebral Hemorrhage | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days | | | |
| DUE TO, OR AS A CONSEQUENCE OF: (b) Hypertension | | | | | | | | years 13 | | | |
| DUE TO, OR AS A CONSEQUENCE OF: (c) Diabetes mellitus with Nephropathy | | | | | | | | years years | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/28 , 19 86 , to 1/28 , 19 86 , that (I) (we) lost saw the deceased live on 1/28 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (and not) saw the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Paul Schwartz M.D. | | | | DEGREE M.D. | | | | 22c. DATE SIGNED 1/28/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul Schwartz M.D. | | | | 22e. ADDRESS 6804 Park Heights Ave 21215 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 2/3/86 | | 23c. NAME OF CEMETERY OR CREMATORY md. Vets Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Dwings Mills md. | | | | |
| 24. FUNERAL DIRECTOR NAME Chatman-HARRIS FH | | | | | ADDRESS 1701 McGuffey St. | | 25a. DATE RECEIVED BY REG. NO. 75b. REGISTRAR'S SIGNATURE JAN 30 1986 | | | | |

MEDICAL CERTIFICATION

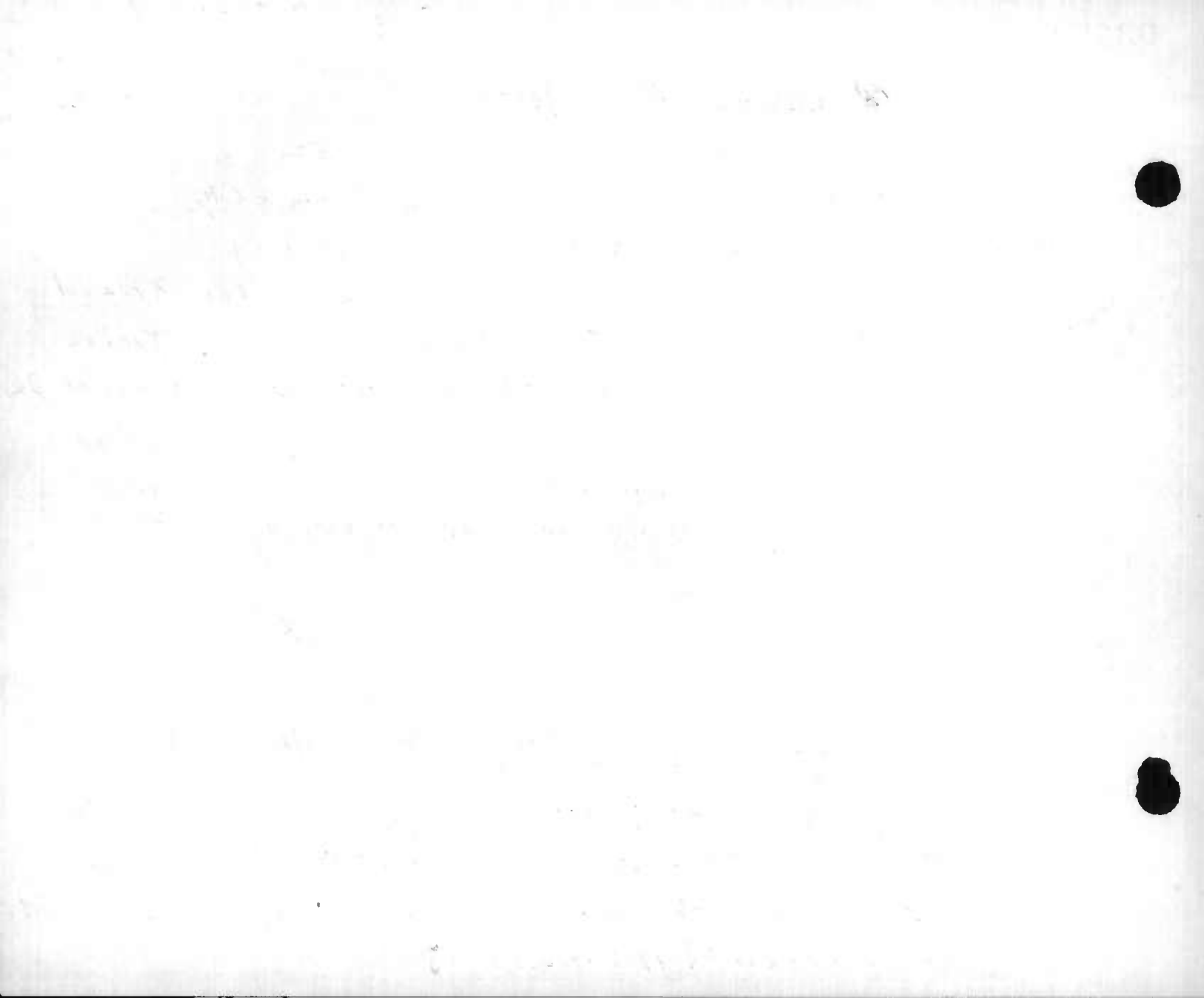
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



038154

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01208

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|--|--|--|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Maynard Jobe Maynard E. Jobe | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 28 86 | | 2b. HOUR 1 47 P.M. | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR 11 30 07 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS HOURS MIN. | | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 10. CITIZEN OF WHAT COUNTRY? USA | | 11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 12. CITY OR TOWN OF DEATH Baltimore | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore Gen. Hospital | | 14. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD. | | |
| 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 15a. STATE MD | | 15b. COUNTY Anne Arundel | | 15c. CITY OR TOWN Glen Burnie | | |
| 16. FATHER'S NAME FIRST MIDDLE LAST Harry M. Jobe | | 17. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hannah Fritz | | 18. STREET ADDRESS / ZIP CODE 343 Cholet Dr. 21061 | | |
| 19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 20. SOCIAL SECURITY NO. WW II 216-05-4507 | | 21. INFORMANT ADDRESS Geoffrey R. Jobe, 10538 Gateridge Rd. Cockeysville, MD | | |
| 22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Severe Malnutrition</u> | | | | | | |
| 23a. DATE OF OPERATION | | 23b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 23c. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 24a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 24b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 25a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 25b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 25c. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 26. I certify that (I) (this hospital) attended the deceased from <u>12/10</u> , 19 <u>85</u> , to <u>1/28</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>1/28</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 27a. SIGNATURE <u>Leonard Y. Lamontano</u> | | 27b. DEGREE MD | | 27c. DATE SIGNED 1-28-86 | | |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT) Leonard Lamontano | | 27e. ADDRESS 3001 S. Hanover St. Balt, MD 21230 | | | | |
| 28a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Cremation | | 28b. DATE Jan. 30, 86 | | 28c. NAME OF CEMETERY OR CREMATORY Security Process, Inc | | |
| 28d. LOCATION CITY OR TOWN Catonsville | | 28e. COUNTY Baltimore | | 28f. STATE MD | | |
| 29. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, MD | | 30. DATE REC'D. BY REGISTRAR FEB 01 1986 | | 31. REGISTRAR'S SIGNATURE <u>William H. Anderson</u> | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2. Please file 103 within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the attending physician should complete item 22.

BP



009120

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01209

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|---|--|--|---|--|--|--------------------------------------|--|--|---|--|--|----------|--|--|-------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | | | MIDDLE | | | LAST | | | 20. DATE KNOWN OF ESTI- DEATH MATED | | | MONTH | | | DAY | | | YEAR | | | 26. HOUR | | |
| Alice | | | Johnson | | | | | | | | | <input checked="" type="checkbox"/> | | | 1/2/ | | | 19 | | | 86 | | | M | | |
| 3 SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS) | | | IF UNDER 1 YR. | | | IF UNDER 24 HRS. | | | 21. DATE PRONOUNCED DEAD | | | 24. HOUR | | | | | |
| female | | | black | | | 11 25 1916 | | | 69 YRS. | | | | | | | | | 1/2/ | | | 1986 | | | 4:33 P M | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED | | | <input checked="" type="checkbox"/> NEVER MARRIED | | | <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| S. C. | | | U S A | | | WIDOWED | | | <input type="checkbox"/> DIVORCED | | | <input type="checkbox"/> | | | Baltimore City, | | | | | | | | | MD. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | |
| Baltimore | | | Provident Hospital | | | Unemployed | | | | | | | | | | | | | | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS | | | 21216 | | | | | | | | | | | |
| Md | | | | | | Baltimore | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 3926 Norfolk Avenue | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | |
| FIRST MIDDLE LAST | | | | | | FIRST MIDDLE LAST | | | | | | | | | | | | | | | | | | | | |
| Ernest | | | | | | Leach | | | | | | Mary | | | | | | Cooley | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | 17. INFORMANT | | | | | | ADDRESS | | | | | | | | |
| No | | | | | | 218-07-2139 | | | | | | George Johnson | | | | | | 3926 Norfolk Avenue | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) <u>DUE TO, OR AS A CONSEQUENCE OF</u> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) <u></u> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? | | | | | | | | | | | | | | |
| | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> <u>Accident</u> <input type="checkbox"/> <u>Suicide</u> <input type="checkbox"/> <u>Homicide</u> <input type="checkbox"/> <u>Undetermined manner</u> <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | | | | |
| TITLE (SPECIFY) M.D. <u>Assistant</u> MEDICAL EXAMINER | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DATE SIGNED <u>1/3/86</u> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) <u>Gregory R. Kauffman, M.D.</u> ADDRESS <u>111 Penn St.</u> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | | 23b. DATE | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | |
| Burial | | | | | | 1/7/86 | | | | | | King Memorial Park | | | | | | Randallstown Md | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | |
| William C. March F/H West 4300 Wabash Avenue | | | | | | | | | | | | JAN 7 1986 | | | | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PRELUCE OF ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

1904

009144

1- FOR
STATE
REGISTRARSTATE OF MARYLAND 8 6
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2a. DATE OF DEATH MONTH DAY YEAR 1/3/86 2b. HOUR 11:39 PM

1. DECEASED NAME FIRST MIDDLE LAST Alonzo C. Johnson

3. SEX Male

4. RACE White

5. DATE OF BIRTH MONTH DAY YEAR 8 07 1907

6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS

IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD

10. CITY OR TOWN OF DEATH Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) S.B.G.H.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired-Super.Main.W. 12b. KIND OF BUSINESS OR INDUSTRY Grace

13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD 13c. COUNTY A.A.Co. 13d. CITY OR TOWN Brookyn Pk.

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE 128 Bon Air Ave, Baltimore MD 21225

14. FATHER'S NAME FIRST MIDDLE LAST Dale Addison - Johnson

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Bathgate

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No

16b. SOCIAL SECURITY NO. 215077637

17. INFORMANT ADDRESS Dake Johnson - son Same as above

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a) Respiratory Failure - Hypoxemia

DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure

DUE TO, OR AS A CONSEQUENCE OF (c) Azotemia 2° Chronic Lung Failure

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Possible Sepsis (b) Anemia (c) Hx of COPD (d) Hx HASCAD

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY YES ☒ NO ☐20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☒ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ AT WORK NOT WHILE ☐ AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/3/86 1986 to 1/3 1986 that (I) (we) lost saw the deceased alive on 1/3 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Maria E. Rodriguez

DEGREE ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED 1/3/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT) Maria E. Rodriguez MD

22e. ADDRESS South Baltimore General Hospital

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

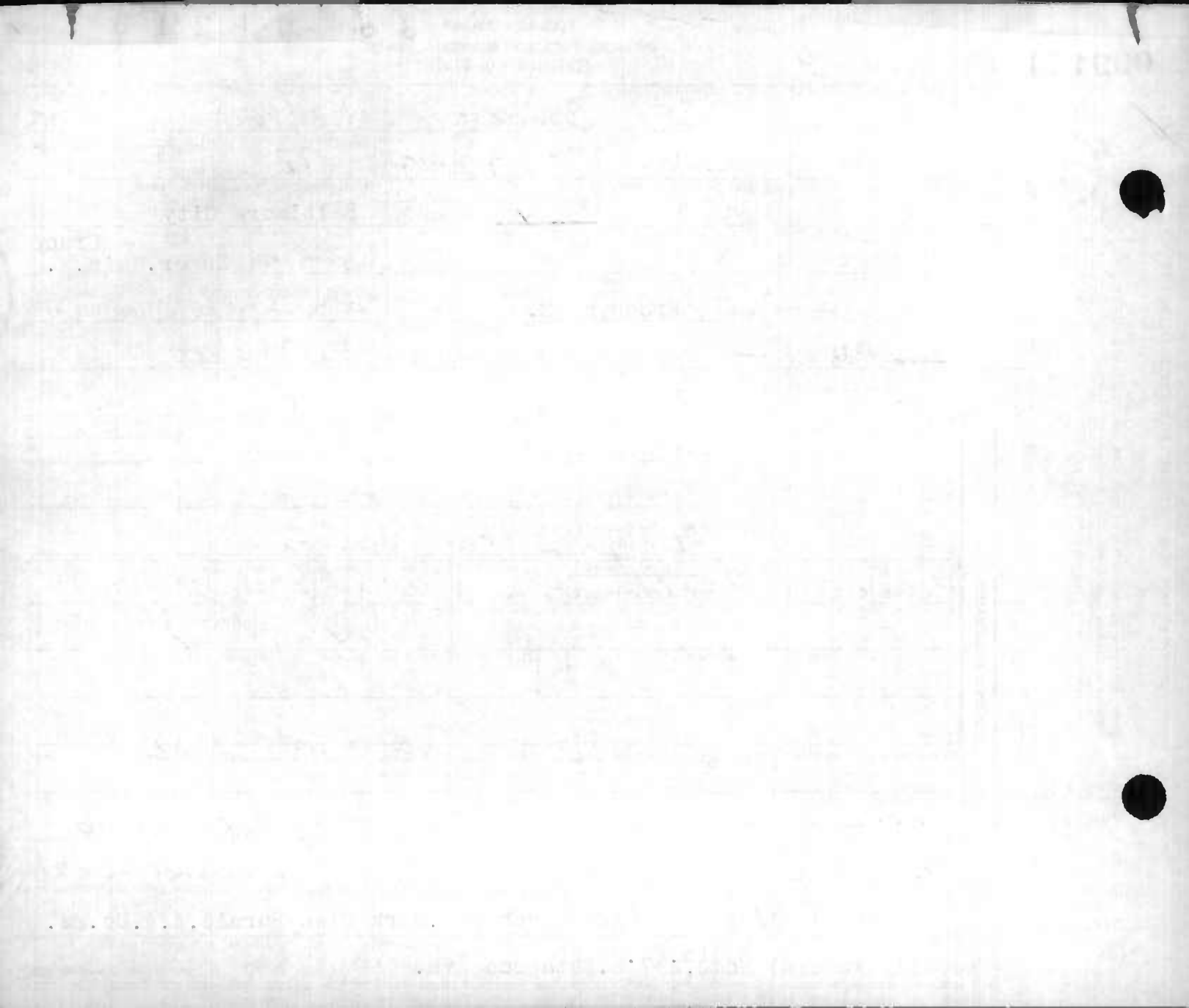
23b. DATE 1/8/1986

23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park

23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, A.A.Co. Md.

24. FUNERAL DIRECTOR NAME Balto. Md. 21225 McCully Funeral Home, 237 E. Patapsco Ave.

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 7 1986



028085

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low number that the death certificate is executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified by page 4.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|---|--|--|--------------|---|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST Annie | MIDDLE A. | LAST Johnson | 2a. DATE OF DEATH January 22, 1986 | | 2b. HOUR M | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 10 16 1888 | | 6. AGE (IN YEARS LAST BIRTHDAY) 97 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 119 S. Kossuth Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE MD | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 119 S. Kossuth St. 21229 |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles Stewart | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Chase | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-36-2854 A | | 17. INFORMANT ADDRESS Georgia Bobbit 119 S. Kossuth Street | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>HEPATOCELLULAR CARCINOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 MONTHS</u> | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-04-1985</u> to <u>10-25-1985</u> , that (I) (we) lost saw the deceased alive on <u>10-25-1986</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE <u>Raulo M. Malhotra</u> | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1-23-86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. MALHOTRA | | | | 22e. ADDRESS ST. AGNES HOSPITAL 900 CATON AVE, BALTIMORE, MD 21229 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/27/86 | | 23c. NAME OF CEMETERY OR CREMATORY Brooks United Meth Ch | | 23d. LOCATION CITY OR TOWN COUNTY STATE Calvert Co Md | | |
| 24. FUNERAL DIRECTOR NAME William C. March F/H 4300 Wabash Avenue | | | | 25. DATE REC'D BY REGISTRAR JAN 24 1986 | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | |

BP

37811 MOTION NO. 2

CINDY
MAY 23 1977



BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it must be submitted to the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| FOR STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|---|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) AKA FIRST BERTIE MIDDLE LAST Birdie Johnson | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 29 86 | | | | 2b. HOUR 2:45 P.M. | | | |
| 3. SEX Female | | 4. RACE Cauc | | 5. DATE OF BIRTH MONTH DAY YEAR 9 26 18 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY ===== 13c. CITY OR TOWN Baltimore | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 1425 Beason St / 21230 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Syath | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FRANCES GOODMAN | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 215 705 004 | | 17. INFORMANT ADDRESS ROSEMARY JOHNSON 1109 S. Hanover Street Balto. Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive Arteriosclerotic Cardiovascular Disease | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan. 13 19 86 , to Jan. 24 19 86 , that (I) (we) lost saw the deceased alive on Jan. 24 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Mitchell Jelen, M.D. | | | | DEGREE M.D. | | | | 22c. DATE SIGNED 1-24-86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mitchell Jelen | | | | 22e. ADDRESS 3001 S. Hanover St. Balto MD 21230 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/27/86 | | 23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Baltimore Md | | | | | |
| 24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hwy Balto Md | | | | | | 25a. DATE REC'D. BY REGISTRAR IAN 28 1986 | | 25b. REGISTRAR'S SIGNATURE John Davidson-Randall | | | |

pd

036013

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

01213

| | | | | | | | |
|--|--|---|---|---|-------------------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DARRELL S JOHNSON | | | 2a. DATE OF DEATH MONTH DAY YEAR 1/30/86 | | 2b. HOUR MIN. 12:40 PM | | |
| 3. SEX MALE | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 9 17 56 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 29 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | | 13b. CITY BALT | | 13c. CITY OR TOWN BALT | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Unknown | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Johnson | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (TYPE, DATES, UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-68-5452 | |
| 17. INFORMANT ADDRESS Kevin Johnson | | 18. CAUSE OF DEATH (Enter only one cause per line for 1a), (1b), and (1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-Pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) INTRACRANIAL & INTRAVENTRICULAR Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) this hospital attended the deceased from 8/1/26 19 86 , to 1/30 19 86 , that (1) I have just saw the deceased alive on 1/30 19 86 , and that in (my) four opinion death occurred on the date and hour and I am the causes stated above, (1) (two) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE J. Michael Randle | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/30/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. MICHAEL RANDLE | | 22e. ADDRESS 22 South Greens St. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 2-3-86 | | 23c. NAME OF CEMETERY OR CREMATORY EAST View Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD. | |
| 24. FUNERAL DIRECTOR NAME Betts Funeral Home | | ADDRESS 1129 N. Carroll St. | | 25a. DATE REC'D. BY REGISTRAR FEB 03 1986 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified to go over.

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021012

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

01214

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|--|---|-----------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) ELIZABETH V Dhanon | | | 2a. DATE OF DEATH MONTH DAY YEAR 01 07 86 | | 2b. HOUR 2:37 PM |
| 3. SEX Female | 4. RACE Negro | 5. DATE OF BIRTH MONTH DAY YEAR 02 14 21 | | 6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. | 7b. CITIZEN OF WHAT COUNTRY? US | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALT. CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALT. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CONVULSION HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE MARYLAND | | 13b. COUNTY | 13c. CITY OR TOWN BALTIMORE | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ROGER FERGUS | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RUSSIE COOK | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 212 28 0943 | | 17. INFORMANT ADDRESS MISS CLAUDETTE J. JOHNSON 1918 WALBROOK AVE 21217 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Uremia DUE TO, OR AS A CONSEQUENCE OF (c) Cervical Cancer. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Alan Berber | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/7/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alan Berber | | 22e. ADDRESS Convulsion Hospital BALT. md 21201 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 1-13-86 | | 23c. NAME OF CEMETERY OR CREMATORY Crownview V.A. Cem | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Crownview A.A. Co. Mo | | 25a. DATE RECD. BY REGISTRAR JAN 17 1986 | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS JOSEPH L. RUS 2222 W. NORTH AVE | | 25b. REGISTRAR'S SIGNATURE | | | |

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

01215

| | | | | | | |
|--|---|--|---------|--|---|---|
| 1 DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a DATE OF DEATH MONTH DAY YEAR | 2b HOUR |
| ETHEL | | | JOHNSON | | January 14, 1986 | 7:05 AM |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH MONTH DAY YEAR | | 6 AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| Female | Negro | 9 17 38 | | 47 YRS | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b CITIZEN OF WHAT COUNTRY? | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | |
| South Carolina | U.S.A. | | | Baltimore City MD. | | |
| 10 CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | Maryland General Hospital | | | Unemployed | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13b INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13c STREET ADDRESS / ZIP CODE | |
| M.D. | | | | | 3320 Edmondson Ave 21229 | |
| 14 FATHER'S NAME | | 15 MOTHER'S MAIDEN NAME | | | | |
| John | | Inez | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT ADDRESS | | |
| No | | | | Sheila Jordan 2010 N. Charles St. | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anatomic findings insufficient to explain death</u> DUE TO, OR AS A CONSEQUENCE OF, <u>probable lithium toxicity by history</u> (b) <u>Visceral edema and congestion</u> (c) <u>Visceral edema and congestion</u> | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a I certify that (a) this hospital attended the deceased from <u>1/14</u> 19 <u>86</u> to <u>1/14</u> 19 <u>86</u> , that (X) we last saw the deceased alive on <u>1/14</u> 19 <u>86</u> and that in (b) (our) opinion death occurred on the date and hour and from the causes stated above, (b) we (did) (did not) view the body after death. <u>XX</u> | | | | | | |
| 22b SIGNATURE | | DEGREE | | | 22c DATE SIGNED | |
| Timothy Low, M.D. / William Tan, M.D. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 1/15/86 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e ADDRESS | | | | |
| Timothy Low, M.D. / William Tan, M.D. | | c/o Maryland General Hospital | | | | |
| 23a BURIAL, CREMATION, REMOVAL | 23b DATE | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION CITY OR TOWN | COUNTY | STATE |
| BURIAL | 1-18-86 | King Mem Park | | BALTO | M.D. | |
| 24 FUNERAL DIRECTOR NAME | | 24b ADDRESS | | 25a DATE REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE | | |
| Ked Funeral Home | | 3209 York Rd | | JAN 17 1986 | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

0210130

20% COTTON FIBER

HEAVY DOWD



013022

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8-6- 01216

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|---|--|---|---|--|----------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRIEDA G. JOHNSON | | | 2a. DATE OF DEATH MONTH DAY YEAR January 7, 1986 | | 2b. HOUR 10:00 M | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR June 27, 1913 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA | | 8. CITIZEN OF WHAT COUNTRY? USA | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 550 Benninghaus Road | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | | 13a. STATE MD | | |
| 13b. COUNTY Balto. | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET ADDRESS / ZIP CODE 550 Benninghaus Rd., 21212 | | 14. FATHER'S NAME FIRST MIDDLE LAST Stanley Dombrosky | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Stella Escazage | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 212 22 8431 | | 17. INFORMANT ADDRESS Jane P. Gilbert, Same | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (b) Debris Mellitus DUE TO, OR AS A CONSEQUENCE OF (c) Congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Congestive heart failure | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (a) (this hospital) attended the deceased from 12-18 19 85 , to 1/7 19 86 , that (b) (we) last saw the deceased alive on 12-18 19 85 , and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above (d) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE [Signature] | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1-8-86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Ebrahim Ipakchi, MD | | 22e. ADDRESS 7401 Osler Dr., Towson, MD 21204 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 1/10/86 | | 23c. NAME OF CEMETERY OR CREMATORY Green Mount | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Balto., MD | | 24. FUNERAL DIRECTOR NAME ADDRESS Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212 | | | | |
| 25a. DATE REC'D. BY REGISTRAR JAN 9 1986 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place remains in container. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. (See instructions on reverse of page 1.)

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

030051

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

01217

REG. NO.

| | | | | | | | | | | |
|---|--|---|---|---|--|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HESTER Johnson | | | 2a. DATE OF DEATH MONTH DAY YEAR 01 26 86 | | | 2b. HOUR 5:30 P.M. | | | | |
| 3. SEX FEMALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 12 12 16 | | 6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South BALTIMORE GEN. HOSP | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Md | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 5238 Park Heights Ave 21215 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 052-14-451 | | 17. INFORMANT ADDRESS Padwa Johnson 5238 Park Heights Ave | | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) SEPSIS DUE TO, OR AS A CONSEQUENCE OF (c) DIABETES Mellitus PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Multiple Decubitus APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| 19a. DATE OF OPERATION 01-20-86 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED SACRAL DECUBITUS | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 01/26/86 to 01/26/86 , that (I) (we) lost saw the deceased alive on 01/26/86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Kwang N. Kim | | | DEGREE MD | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/26/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) KWANG N. KIM | | | 22e. ADDRESS 3001 S. HANOVER ST. Balto. 21225 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1/29/86 | | 23c. NAME OF CEMETERY OR CREMATORY Eastview Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md | | | |
| 24. FUNERAL DIRECTOR NAME William C. March F/H West | | | | | ADDRESS 4300 Wabash Avenue | | 25a. DATE REC'D. BY REGISTRAR 1 JAN 28 1986 | | 25b. REGISTRAR'S SIGNATURE John Davidson-Randall | |

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Pa

UNITED STATES

MAILED



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

01218

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|---|--|--|--|---|
| 1 DECEASED NAME (TYPE OR PRINT) JACQUELINE A. JOHNSON | | | 2a DATE OF DEATH MONTH DAY YEAR JANUARY 3, 1986 | | 2b HOUR P 10:10 |
| 3 SEX FemALE | 4 RACE Caucasion | 5 DATE OF BIRTH MONTH DAY YEAR 4 24 1941 | | 6 AGE (IN YEARS LAST BIRTHDAY) 44 YRS | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | 7b CITIZEN OF WHAT COUNTRY? USA | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10 CITY OR TOWN OF DEATH BALTIMORE | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assistant Administrative | 12b KIND OF BUSINESS OR INDUSTRY Insurance | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE Md | | 13c CITY OR TOWN Joppa | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS / ZIP CODE 202 Contee Road 21085 |
| 14 FATHER'S NAME FIRST MIDDLE LAST Zacary Frank | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Reynolds | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT ADDRESS Eric Johnson (spouse) Same as 13 | |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a) **cardiac arrest**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) _____
DUE TO, OR AS A CONSEQUENCE OF

(c) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

30 min

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Cancer

MEDICAL CERTIFICATION

| | | | |
|---|--|---|--|
| 19a DATE OF OPERATION | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (this hospital) attended the deceased from 1/3 86 , to 1/3 86 , that (I) (we) last saw the deceased alive on 1/3 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death. | | | |
| 22b SIGNATURE Alex Reiner | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c DATE SIGNED 1/3/86 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Alex Reiner | 22e ADDRESS Johns Hopkins Hospital | | |

| | | | |
|---|---------------------------|--|---|
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | 23b DATE 1-4-86 | 23c NAME OF CEMETERY OR CREMATORY | 23d LOCATION CITY OR TOWN COUNTY STATE |
| 24 FUNERAL DIRECTOR NAME Anatomy Board | | ADDRESS Baltimore, Maryland | |
| 25a DATE REC'D BY REGISTRAR JAN 16 1986 | | 25b REGISTRAR'S SIGNATURE Julia Davidson | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that a death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by a medical physician or completed and signed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury or other traumatic event. Medical examiner will be notified in writing.

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020037

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|--|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LILLIAN BUTLER JOHNSON | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 15 86 | | 2b. HOUR M |
| 3 SEX FEMALE | 4. RACE BLACK | 5. DATE OF BIRTH MONTH DAY YEAR 10 28 1907 | | 6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | |
| 10 CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2711 ALLENDALE ROAD | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED-PRINCIPAL | | 12b. INDUSTRY OR BUSINESS CITY SCHOOLS |
| 13a. STATE MARYLAND | 13b. COUNTY | 13c. CITY OR TOWN BALTIMORE | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 1520 N. APPLETON STREET, BALTIMORE, MD. 21217 |
| 14. FATHER'S NAME FIRST MIDDLE LAST ARTHUR BUTLER | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LAVANIA SODEN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-40-5593 | 17. INFORMANT 2711 ALLENDALE ROAD GEORGE JOHNSON BALTIMORE, MARYLAND 21216 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEPATIC FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC COLON CANCER TO LIVER</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>COLD-RECTAL CANCER</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>1 year</u> <u>2 years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7</u> 19 <u>84</u> to <u>1</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>12</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>JAMES V. VIREMAN</u> | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES V. VIREMAN | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 1/20/86 | 23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEMORIAL PARK | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MARYLAND |
| 24. FUNERAL DIRECTOR NAME ADDRESS NUTTER & SONS FUNERAL HOME, INC. 2501 GWYNNS FALLS PKWY. BALTIMORE, MD. 21216 | | | 25a. DATE RECD. BY REGISTRAR JAN 16 1986 | | 25b. REGISTRAR'S SIGNATURE <u>Durdon</u> |

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UNDO

REBEL NO 100 2002

WETTING



020044

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Oliverne Johnson | | | 2a. DATE OF DEATH MONTH DAY YEAR 01-10-86 | | | 2b. HOUR M | | | |
| 3. SEX Female | | 4. RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR 01-23-42 | | 6. AGE (IN YEARS LAST BIRTHDAY) 43 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Jamaica | | 7b. CITIZEN OF WHAT COUNTRY? BWI | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sherraton Hotel | | 12b. KIND OF BUSINESS OR INDUSTRY House Keeping | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY B | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Mc Nish | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | | |
| 16b. SOCIAL SECURITY NO. 218-02-0567 | | 17. INFORMANT NAME ADDRESS John Johnson 1065 W Lexington St. Balto, Md. | | | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **METASTATIC CARCINOMA LUNG**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **PNEUMONIA**

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION NIL | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NIL | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR NIL | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) NIL | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) NIL | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1-10 86 | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-6-86 to 1-10-86 , that (I) (we) lost saw the deceased alive on 1-10-86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death. | | | | | | | |
| 22b. SIGNATURE Surjit | | | | DEGREE JULIA | | 22c. DATE SIGNED 1-10-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SURJIT JULIA | | | | 22e. ADDRESS BON SECOURS HOSPITAL BALTIMORE | | | |

| | | | | | | | |
|---|--|-----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/18/86 | | 23c. NAME OF CEMETERY OR CREMATORY Md. Nat. Mem. Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Laurel, Md. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Wm C March F/H West 4300 Wabash Ave. | | | | 25a. DATE REC'D BY REGISTRAR JAN 18 1986 | | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | | |

MEDICAL CERTIFICATION

050071

8W



100% COTTON FIBER



WASH & TUMBLE DRY

016033

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. (IF NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | | |
|--|--|-------------------------|--|---|--|--|--|--|--|---|--|----------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PATRICIA Rosesina JOHNSON | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1-10-86 19 | | 2b. HOUR M | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 26, 1957-28 | | 6. AGE IN YEARS (LAST BIRTHDAY) MONTHS DAYS HOURS MIN YRS. | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1-10-86 19 | | 7d. HOUR 7:02P | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hohenwald, Tenn. | | | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital STU | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cashier -Food Serv.-Din- | | 12b. KIND OF BUSINESS OR INDUSTRY ing | | | |
| 13a. STATE Md. | | | | 13b. COUNTY Arundel Cty | | 13c. CITY OR TOWN Glen Burnie | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 204 Marie Ave. -21062 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Roy Lee Johnson | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Geraldine Robinson | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) IF YES, GIVE WAR OR DATES No | | | | 16b. SOCIAL SECURITY NO. 413-96-9943 | | 17. INFORMANT Severn, ADDRESS Md. 21144 Henry Robinson-8214 Coatsbridge Ct. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8120 IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR MIN MONTH DAY YEAR 1:40 P.M. 1-10-86 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver of an auto/auto head-on collision | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) hwy. | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE St. Rt. 176&780ft. W. of Anne Arundel Co., Md. Diquids Drive | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Margarita A. Korell | | | | TITLE (SPECIFY) M.D. Assistant | | | | DATE SIGNED 1-11-86 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE Jan. 17, '86 | | 23c. NAME OF CEMETERY OR CREMATORY Hohenwald Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Hohenwald, Lewis Cty, Tenn. | | | |
| 24. FUNERAL DIRECTOR Sterling Funeral Estate, P.A. 25a. DATE REC'D BY REGISTRAR JAN 13 1986 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | | | | | | | | | |
| 736 Edmondson Ave.; Catonsville, Md. 21228 | | | | | | | | | | | | | |

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 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

01222

 1- FOR
 STATE
 REGISTRAR

REG. NO.

| | | | | | |
|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) PEARL JOHNSON | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 9 86 | | 2b. HOUR 3:17 AM |
| 3. SEX FEMALE | 4. RACE NEGRO | 5. DATE OF BIRTH MONTH DAY YEAR 5 5 16 | | 6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. CAROLINA | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD. | |
| 10. CITY OR TOWN OF DEATH BALTO. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Maryland | | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOHNSON | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Henrietta Johnson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 213-16-3090 | | 17. INFORMANT ADDRESS David Johnson 21229 629 Linnard Avenue | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) 4 years | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) None | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (his hospital) attended the deceased from Jan 9 1986 to Jan 9 1986 , that (I) (we) last saw the deceased alive on Jan 9 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Manuel Levin MD | | DEGREE MD | | 22c. DATE SIGNED 1/10/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MANUEL LEVIN, M.D. | | 22e. ADDRESS 6101 PARK HILLS AVE BALTIMORE MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/14/86 | | 23c. NAME OF CEMETERY OR CREMATORY Eastview Mem. Pk | |
| 24. FUNERAL DIRECTOR NAME Leroy O. Dyett | | ADDRESS 4600 Liberty Hghts. Ave. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balt., Md. | |
| 25a. DATE REG'D. BY REGISTRAR JAN 14 1986 | | 25b. REGISTRAR'S SIGNATURE Jane Anderson-Randall | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be advised at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and released to the funeral director, page 2 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME (Type in full) (BB) Robert Lee JOHNSON, JR. | | | 2a. DATE OF DEATH MONTH DAY YEAR JAN. 31, 1986 | | | 2b. HOUR 9:50P M | | | |
| 3. SEX MAle | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 1 31 86 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 4 | | IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland | | | 13c. COUNTY Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 6407 Laurelton Avenue 21214 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Robert Lee Johnson, Sr. | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Valgene James | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | | 16b. SOCIAL SECURITY NO. N/A | | 17. INFORMANT ADDRESS Robert L. Johnson 6407 Laurelton Avenue | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>severe congenital heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1/31/86 at 4pm</u> <u>1/31/86 at 4pm</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4:40pm 1/31</u> , 19 <u>86</u> , to <u>9:50pm 1/31</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>1/31</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Y. Stuy</u> | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED <u>1/31/86</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Y. Stuy</u> | | | | | 22e. ADDRESS <u>600 N. WOLF ST BALTO, MD. 21205</u> <u>Johns Hopkins Hospital</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 2/4/86 | | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus, Md. | | |
| 24. FUNERAL DIRECTOR March Funeral Homes 1101 East North Avenue | | | | | 25a. DATE REC'D BY REGISTRAR FEB 05 1986 | | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | |
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| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RODERICK F. JOHNSON | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 22 86 | | 2b. HOUR 2:41 PM | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 10 9 25 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS | | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A | | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| 13a. STATE Maryland | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Handy | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alberta Lewis | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-20-6932 | | 17. INFORMANT ADDRESS Audrey A. Hall 2423 Barclay Street | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/21</u> 19 <u>86</u> to <u>1/22</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>1/22</u> 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE <u>Robert Vissing</u> | | DEGREE MD | | 22c. DATE SIGNED 1/22/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT VISSING, M.D. | | 22e. ADDRESS UNION MEMORIAL HOSPITAL | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 1/27/86 | | 23c. NAME OF CEMETERY OR CREMATORY Garrison Forest VA. | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE OWings Mills, Md. | | | | | | |
| 24. FUNERAL DIRECTOR NAME March Funeral Homes 1101 East North Avenue | | 25a. DATE REC'D. BY REGISTRAR JAN 24 1986 | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 of 4 to be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

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| | | | | | | | | | | | |
|--|--|--|--|---|--|--|---|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Stanley R Johnson | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 6 86 | | | 2b. HOUR 3:50 PM | | | | | |
| 3. SEX MALE | | 4. RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR 9 04 36 | | 6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 1127 N Bead street 21213 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Benjamin Johnson | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hollie Marks | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | 16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 212-32-6833 | | | 17. INFORMANT Ruby Rice | | | ADDRESS 5506 Bell Avenue | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>hypotension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>chronic renal failure</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 25 minutes 24 hours 3 years | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Congestive heart failure, Gastrointestinal bleed</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>January 6, 1986</u> , to <u>January 6, 1986</u> , that (I) (we) last saw the deceased alive on <u>January 6, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Michelle F Newton</u> | | | | | | DEGREE MD | | | 22c. DATE SIGNED <u>January 6, 1986</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Michelle F Newton MD</u> | | | | | | 22e. ADDRESS <u>Good Samaritan Hospital Baltimore, MD 21239</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u> | | | 23b. DATE <u>1-13-86</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Arbutus</u> | | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Arbutus MARYLAND</u> | | | |
| 24. FUNERAL DIRECTOR NAME <u>W.M.C. March F/H Inc.</u> | | | | | | ADDRESS <u>1101 E. North Ave.</u> | | | 25a. DATE REC'D. BY REGISTRAR <u>JAN 10 1986</u> | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | | |

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20% COTTON FIBER

MADE IN
UNITED STATES



031011

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

0 1 2 2 6

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) Norman Gregory Joines | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 17 86 | | 2b. HOUR 3 55 PM |
| 3. SEX MALE | 4. RACE white | 5. DATE OF BIRTH MONTH DAY YEAR 09 08 48 | 6. AGE (IN YEARS LAST BIRTHDAY) 37 YRS | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) — | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Maryland Shock Trauma | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) construction worker | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | 13b. CITY OR TOWN Perryville | | |
| 13c. STREET ADDRESS / ZIP CODE 12627 Belair Rd 21087 | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Norman Joines | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Betty Brittingham | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 222-30-9881 | | |
| 17. INFORMANT ADDRESS Patricia Lynn Baker - Millsboro, Del. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain Anoxia DUE TO, OR AS A CONSEQUENCE OF (b) Spasms / Low Flow State DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ARDS | | | | | |
| 19a. DATE OF OPERATION 12/17/85 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/17 19 85 to 1/18/86, that (I) (we) lost saw the deceased alive on 1/18/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) see the body after death. | | | | | |
| 22b. SIGNATURE [Signature] | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/17 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. A. | | 22e. ADDRESS 22 S. Green St. Baltimore, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) cremation | 23b. DATE 1/18/86 | 23c. NAME OF CEMETERY OR CREMATORY Delmarva Crematory | 23d. LOCATION CITY OR TOWN COUNTY STATE Lewes, Delaware | | |
| 24. FUNERAL DIRECTOR NAME Richard T. Watson | | ADDRESS Millsboro, Del. | | 25a. DATA RECD. BY REGISTRAR JAN 27 1986 | |
| | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permits. Their please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified of case.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|--|---|---|--|--|--|--|-----------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Carolyn Jones | | | | | 2a. DATE OF DEATH MONTH DAY YEAR January 17, 1986 | | | 2b. HOUR M | | | |
| 3 SEX Female | | 4 RACE Black | | 5 DATE OF BIRTH MONTH DAY YEAR 5 4 53 | | 6. AGE (IN YEARS LAST BIRTHDAY) 32 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD. | | | | | |
| 10 CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1606 E. Monument Street | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE Apt. 11 1606 E. Monument Street 21205 | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Lassiter Miller | | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hyla Lee | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT ADDRESS Rufus Jones 1606 E. Monument St. Apt. 11 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastro Intestinal bleeding</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cirrhotic liver</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Alcoholism</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>R. Jones</u> DEGREE <u>MD</u> | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 1/21/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>M. K. HAN</u> | | | | | | 22e. ADDRESS <u>2717 HAMMONDS Ferry Rd BALTO MD 21227</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE) BURIAL | | | 23b. DATE 1/22/86 | | 23c. NAME OF CEMETERY OR CREMATORY Mount Auburn Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md. | | | | |
| 24 FUNERAL DIRECTOR NAME March Funeral Home s 1101 East North Avenue | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 22 1986 | | 25b. REGISTRAR'S SIGNATURE <u>J. Davidson</u> | | | |

MEDICAL CERTIFICATION

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <i>LAST</i> <i>Jones</i> MIDDLE <i>DELLA</i> | | 2a. DATE OF DEATH MONTH <i>11</i> DAY <i>3</i> YEAR <i>1986</i> | | 2b. HOUR <i>5:50 PM</i> | |
| 3. SEX <i>F</i> | | 4. RACE <i>B</i> | | 5. DATE OF BIRTH MONTH <i>7</i> DAY <i>4</i> YEAR <i>27</i> | |
| 6. AGE (IN YEARS LAST BIRTHDAY) <i>58</i> YRS | | IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i> | | IF UNDER 24 HRS. HOURS <i></i> MIN. <i></i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>S.C.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore</i> MD. | | 10. CITY OR TOWN OF DEATH <i>BALTIMORE</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Mason F. Lord</i> | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOUSEWIFE</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE <i>MARYLAND</i> | | 13b. COUNTY | | 13c. CITY OR TOWN <i>BALTIMORE</i> | |
| 14. FATHER'S NAME FIRST <i>ERDUS</i> MIDDLE <i></i> LAST <i>JONES</i> | | 15. MOTHER'S MAIDEN NAME FIRST <i>NORA</i> MIDDLE <i></i> LAST <i>DAVIS</i> | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i> | | 16b. SOCIAL SECURITY NO. <i>705-10-9479</i> | | 17. INFORMANT ADDRESS <i>NORA JONES 1202 EAST EAGER STREET</i> | |
| 18. CAUSE OF DEATH Enter only one cause per line for part (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ce of lung c mets & brain</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Bil BKA with associated Visual impairment</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i></i> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11/11</i> , 19 <i>85</i> , to <i>11/31</i> , 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>11/31</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (each) did not view the body after death. | | | | | |
| 22b. SIGNATURE <i>John T. Boyer</i> DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <i>2/3/86</i> | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John T. Boyer MD</i> | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SELECT) <i>BURIAL</i> | | 23b. DATE <i>2-6-86</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>BALTIMORE</i> | |
| 23d. LOCATION CITY OR TOWN <i>BALTIMORE</i> COUNTY <i>MARYLAND</i> STATE | | 24. FUNERAL DIRECTOR NAME <i>WM.C.MARCH F/H INC.</i> ADDRESS <i>1101 E. NORTH AVE.</i> | | 25a. DATE REC'D. BY REGISTRAR <i>FEB 05 1986</i> 25b. REGISTRAR'S SIGNATURE <i>Lina Davidson-Randall</i> | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, independent autopsy should be considered and notified of intent.

BP

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2% COTTON FIBER

100% COTTON FIBER

Transferred from

110800

022038

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELBERT L. JONES | | 2a. DATE OF DEATH MONTH DAY YEAR 1 - 18 - 86 | | 2b. HOUR 9:50 AM | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 6 6 14 | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS 71 | | 8. IF UNDER 74 HRS HOURS MIN. 71 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Meat Cutter | |
| 12b. KIND OF BUSINESS OR INDUSTRY Market Stalls | | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY Baltimore | |
| 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 206 E. Eager Street, 21202 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Jones | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amelia | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WWII | |
| 16b. SOCIAL SECURITY NO. 160-05-1635 | | 17. INFORMANT Gregory E. Jones, 206 E. Eager Street, 21202 | | ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Squamous cell carcinoma of the lung DUE TO, OR AS A CONSEQUENCE OF (c) months | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Warm autoimmune hemolytic anemia, post-obstructive pneumonia, | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from 12/19 , 19 85 , to 1/18 , 19 86 , that (I) (we) last saw the deceased alive on 1/18 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE Evan J. Selsky MD | |
| 22c. DEGREE MD | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Evan J. Selsky MD | | 22e. ADDRESS Mercy Hospital - 301 St. Paul Pl. Baltimore Md. 21202 | |
| 22f. DATE SIGNED 1/18/86 | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/ 21/86 | |
| 23c. NAME OF CEMETERY OR CREMATORY Garrison Forest | | 23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills Balto. Maryland | | 24. FUNERAL DIRECTOR NAME ADDRESS Hubbard Funeral Home, 4107 Wilkens Ave. 21229 | |
| 25a. DATE REC'D. BY REGISTRAR JAN 20 1986 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | 25c. REGISTRAR'S SIGNATURE | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

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036031

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|---------------------------|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | |
| 1 DECEASED NAME (TYPE OR PRINT) ELEANOR Beatrice JONES | | | MONTH DAY YEAR 1 29 86 | | | M | | | |
| 3 SEX FEMALE | | 4 RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 4/22/ 1933 | | 6 AGE (IN YEARS LAST BIRTHDAY) 52 YRS | | 7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10 CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 353 N. BEAUMONT AVENUE | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY Balto. County Schools | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 353 N. BEAUMONT AVENUE, BALTIMORE, MARYLAND 21228 | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Leigh A. Allen | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Smith | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 219-30-2159 | | 17 INFORMANT 353 N. BEAUMONT AVENUE CLARENCE JONES BALTIMORE, MARYLAND 21228 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRAIN METASTASES DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC ADENOCARCINOMA OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) UNKNOWN PRIMARY PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 21g. I certify that (1) this hospital attended the deceased from OCTOBER 3, 1985 to JANUARY 27, 1986, that (1) (we) last saw the deceased alive on DECEMBER 30, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If deceased died prior to the body after death. | | | | | | | | | |
| 22a. SIGNATURE DIANA H. GRIFFITHS | | | | 22b. DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 1/29/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS 900 CATON AVE. BALT. MD. 21229 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial | | 23b. DATE 2/3/1986 | | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | | | |
| 24 FUNERAL HOME, INC. 2501 Gwynns Falls Pkwy. Baltimore, MD. 21216 | | | | 25a. DATE REC'D. BY REGISTRAR FEB 03 1986 | | 25b. REGISTRAR'S SIGNATURE C. Davidson-Randall | | | |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

041095

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FRANCIS JONES | | | 2a. DATE OF DEATH MONTH DAY YEAR 01 20 86 | | | 2b. HOUR 9:35A M | | | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 3 31 1916 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE, CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VAMC, BALTIMORE MARYLAND | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |

| | | | | | | | | | | | | | | |
|--|--|--|-------------|---|--|---|--|--|---|--|--|---|--|--|
| 13a. STATE Maryland | | | 13b. COUNTY | | | 13c. CITY OR TOWN Baltimore | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE 3474 Dolfield Ave. 21215 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Isaac Suggs | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Flemming | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 220-09-6467-A | | | | 17. INFORMANT ADDRESS Ann Bernices Hunley 3474 Dolfield | | | | | | |

| | | | |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio pulmonary ARREST DUE TO, OR AS A CONSEQUENCE OF (b) SEVERE CHF, Dilated Cardiomyopathy DUE TO, OR AS A CONSEQUENCE OF (c) years | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
|--|--|---|--|

| | | | |
|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Renal FAILURE | | | |
|--|--|--|--|

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE VAMC, BALTIMORE MARYLAND 21218 | | | |

| | | | | | | | |
|---|--|---|--|--|--|-----------------------------------|--|
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12/30 19 85 to 1/20 19 86 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 1/20 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE ASS mr | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | TH. DATE SIGNED 1/21/86 | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS 3900 LOCH RAVEN BLVD. BALTIMORE MARYLAND | | | | | |

| | | | | | | | |
|---|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-24-86 | | 23c. NAME OF CEMETERY OR CREMATORY Garrison Forest | | 23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills, Maryland | |
|---|--|-----------------------------|--|--|--|---|--|

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 24. FUNERAL DIRECTOR NAME Bailey-Douglass Funeral | | ADDRESS 1348 N. Home Calhoun St. | | 25. DATE REC'D. BY REGISTRAR FEB 06 1986 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |
|--|--|--|--|--|--|--|--|

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed in the office after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

0-1103



62

0210938

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 6 0 1 2 3 2

| | | | | | | | | | | | |
|---|--|--|--|--|--------------------------------|--|---|---|--|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) Jean Jones | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 15 86 | | | 2b. HOUR 11:15 P.M. | | | | | |
| 3 SEX Female | | 4 RACE Negro | | 5. DATE OF BIRTH MONTH DAY YEAR 4 3 1919 | | 6 AGE (IN YEARS LAST BIRTHDAY) 66 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10 CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE MD | | | 13b. COUNTY Anne Arundel | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 308 Elizabeth Ave. 21225 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Otis Graves | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Graves | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO. 218 22 8250 | |
| 17. INFORMANT Doretha Jones | | | ADDRESS 308 Elizabeth Ave | | | | | | | | |

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Respiratory Arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Cerebral Vascular Accident

DUE TO, OR AS A CONSEQUENCE OF

(c) Hypertension

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

30 days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0

Disseminated Herpes Zoster

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/16/85, 19_____, to 1/15, 19 1986, that (I) (we) lost saw the deceased alive on 1/15, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE John A. Tygant | | | | DEGREE MD | | 22c. DATE SIGNED 1-11-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) John A. Tygant | | | | 22e. ADDRESS South Balt Gen Hospital. | | | |

| | | | | | | | |
|---|--|----------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL Cremation | | 23b. DATE 1/20/86 | | 23c. NAME OF CEMETERY OR CREMATORY Westview Memorial Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cationsville Balt. Md | |
| 24. FUNERAL DIRECTOR Funell B. Oden - 153 Druid Hill Ave | | | | 25a. DATE REC'D. BY REGISTRAR JAN 17 1986 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE John Davidson-Randall | | | |

BP _____

8

79

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please return completed papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

600150



50% COTTON FIBER



017115

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01233

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 7b. HOUR | |
| Joe | | JONES | | 1-10-86 | | 8 PM | | M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | |
| Male | | Col. 2 | | 3 3 1900 | | 85 | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | MD. | |
| S.C. | | USA | | | | Balto. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Balto. | | JOHN DEATON HOSPITAL | | Laborer | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| Md. | | | | Balto. | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT ADDRESS | |
| Sheldon | | Jones | | Agnes | | Jones | | Killy McCoy - 925 Bennett Pl - 21223 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | PART I. DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | cardiopulmonary arrest | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | (b) | | adenocarcinoma of lungs | | | |
| | | | | (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY STATE | |
| | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/10/86 to 1/10/86, that (I) (we) last saw the deceased alive on 1/10/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22a. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | | | |
| Gail Reedman MD | | | | | | 1/12/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 23a. BURIAL, CREMATION, REMOVAL (TYPE) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| GAIL REEDMAN MD | | 611 S. CHARLES ST BALTO MD | | Burial | | 1/10/86 | | Mt Zion Cem | |
| 23d. LOCATION CITY OR TOWN | | COUNTY | | STATE | | 23e. DATE REC'D. BY REGISTRAR | | 23f. REGISTRAR'S SIGNATURE | |
| Balto | | | | Md | | JAN 14 1986 | | Gail Reedman MD | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Charles H. Powell | | 1206 W. North Ave | | JAN 14 1986 | | | | | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

20% COTTON BLEND

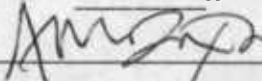

WILSON



014054

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 01234 | |
|--|--|-------------------|--|--|--|--|--|--|--|---|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LILLIAN M. JONES | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 1 7 1986 | |
| 3. SEX F | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR 4 28 04 | | 6. AGE (IN YEARS) LAST BIRTHDAY 81 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | | 2b. DATE PRONOUNCED DEAD 1 7 1986 3:50 PM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 502 Oakland Ave. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 502 OAKLAND AVE. 21212 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST unknown | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 214-03-2388A | | 17. INFORMANT ADDRESS BETTY WILSON 502 OAKLAND AVE. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY) M.D. Assistant | | | | MEDICAL EXAMINER DATE SIGNED 1-10-86 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | | ADDRESS 111 Penn St., Balto., MD 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 1-10-86 | | 23c. NAME OF CEMETERY OR CREMATORY MOUNT ZION | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE LANSDOWNE MARYLAND | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS WM.C.MARCH F/H INC. 1101 E.NORTH AVE. | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 10 1986 | | 25b. REGISTRAR'S SIGNATURE  | | | |

FOX COLTON FIBER

AND

WINDMILL



CT 10:10

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|--|--|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) Marie Cook Jones | | | 2a. DATE OF DEATH MONTH DAY YEAR JAN 17-1986 | | 2b. HOUR 9:15p M |
| 3. SEX Female | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 10-8-1946 | | 6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) va | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RESWICK Nursing Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | 12b. KIND OF BUSINESS OR INDUSTRY at Home | |
| 13a. STATE MD | | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles Cook | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Wendy | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 02922 1130 | | 17. INFORMANT ADDRESS Famela Robinson 1901 McKean Ave | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardio Vascular Arrest DUE TO, OR AS A CONSEQUENCE OF: (b) Possible Aspiration Pneumonia DUE TO, OR AS A CONSEQUENCE OF: (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mins. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Altered Mental Status | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Jos Febles | | DEGREE | | 22c. DATE SIGNED I. 17-1986 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jos Febles | | 22e. ADDRESS 3809 Greenmount Avenue Balto 21218 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | 23b. DATE 1/20/86 | 23c. NAME OF CEMETERY OR CREMATORY Hounggin chuan | | 23d. LOCATION CITY OR TOWN COUNTY STATE Stony Creek Va | |
| 24. FUNERAL DIRECTOR NAME Marshall A. Thompson | | 25a. DATE REC'D. BY REGISTRAR JAN 22 1986 | | 25b. REGISTRAR'S SIGNATURE John Davidson-Randall | |

201150



THE NEW BOWE

022032

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01236

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|---|--|---|--|---|--|--|--------------------------------|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Paul Wade Jones | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 17 86 | | | 2b. HOUR 9:05p M | | | | | |
| 3. SEX MALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR 8 4 44 | | 6. AGE (IN YEARS LAST BIRTHDAY) 41 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OHIO | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN | | 12b. KIND OF BUSINESS OR INDUSTRY ICE CREAM | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | | | | 13b. COUNTY N/A | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DOROTHY C. MOORE | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 214-40-8980 | | 17. INFORMANT Mary Jones Same as #13 | | ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SMALL CELL UNDIFFERENTIATED Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARCINOMA OF THE LUNG WITH (c) EXTENSIVE INVOLVEMENT OF THE MEDIASTINUM PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Michael E Pelczar | | | | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/18/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL E PELCZAR | | | | | | 22e. ADDRESS ST. AGNES HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 1-20-86 | | 23c. NAME OF CEMETERY OR CREMATORY Holly Hills Mem pk | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Essex BALTIMORE MD | | | |
| 24. FUNERAL DIRECTOR NAME Mc Cully F.H. | | | | | | ADDRESS BALTIMORE, MD 237 E Patapsco Ave | | 25a. DATE REC'D. BY REGISTRAR JAN 20 1986 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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RECEIVED
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U.S. AIR FORCE
HONOLULU, HAWAII

RECEIVED
JAN 10 1968
U.S. AIR FORCE
HONOLULU, HAWAII

RECEIVED
JAN 10 1968
U.S. AIR FORCE
HONOLULU, HAWAII

RECEIVED
JAN 10 1968
U.S. AIR FORCE
HONOLULU, HAWAII

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

027088

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 1 2 3 7

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|--|--|---|---|---|----------------------------|--|
| 1 DECEASED NAME (TYPE OR PRINT) <u>Willine NMJ Jordan</u> | | | 2a DATE OF DEATH MONTH <u>1</u> DAY <u>19</u> YEAR <u>86</u> | | 2b HOUR <u>10:15 AM</u> | |
| 3 SEX <u>F</u> | | 4 RACE <u>Black</u> | | 5. DATE OF BIRTH MONTH <u>10</u> DAY <u>11</u> YEAR <u>30</u> | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Md.</u> | | 7b CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | |
| 10 CITY OR TOWN OF DEATH <u>Baltimore</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Univ. of Md. Hospital</u> | | 9 BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore</u> MD. | | |
| 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Disabled</u> | | 12b KIND OF BUSINESS OR INDUSTRY | | | | |

| | | | | | | |
|---|--|---|---|---|--------------------------------------|--|
| 13a STATE <u>Md</u> | | | 13b COUNTY | | 13c CITY OR TOWN <u>Baltimore</u> | |
| 14 FATHER'S NAME FIRST <u>Alexander</u> MIDDLE <u>Blandon</u> LAST <u>Alvada</u> | | | 15 MOTHER'S MAIDEN NAME FIRST <u>Scott</u> MIDDLE <u>Scott</u> LAST <u>Scott</u> | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u> | | 16b SOCIAL SECURITY NO. <u>212-28-7160</u> | | 17 INFORMANT <u>Maria Watson (daughter)</u> | | |
| | | | | ADDRESS <u>6614 Vincent La</u> <u>Baltimore, Md</u> | | |

| | | |
|---|--|---|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Lung cancer w/ metastases</u> DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>19</u> | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |

22a. I certify that (I) (this hospital) attended the deceased from 1/1, 19 86, to 1/19, 19 86, that (I) (we) last saw the deceased alive on 1/19, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | | | | | |
|---|--|---|--|--|--|------------------------------------|--|
| 22b. SIGNATURE <u>Sharon J. McCormack</u> | | DEGREE <u>MD</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>1/19/86</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Sharon J. McCormack</u> | | 22e. ADDRESS <u>University Hospital Greene St. Balh.</u> | | | | | |

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|---|--|-----------------------------|--|---|--|---|--|
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>1/25/86</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Eastview Memorial Park</u> | | 23d. LOCATION CITY OR TOWN <u>Baltimore</u> COUNTY <u>Md</u> STATE <u>Md</u> | |
|---|--|-----------------------------|--|---|--|---|--|

| | | | | | |
|--|--|---|--|----------------------------|--|
| 24 FUNERAL DIRECTOR NAME <u>William C. March F/H West</u> ADDRESS <u>4300 Wabash Avenue</u> | | 25a. DATE REC'D. BY REGISTRAR <u>JAN 23 1986</u> | | 25b. REGISTRAR'S SIGNATURE | |
|--|--|---|--|----------------------------|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

MEDICAL CERTIFICATION

11/10/82

Willie M. Jordan
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|---|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) MARY A Judge | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 6 86 | | | 2b. HOUR 8:15A | | | | |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 2 21 1907 | | 6 AGE (IN YEARS LAST BIRTHDAY) 78 | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | |
| 10 CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY | | 12b. KIND OF BUSINESS OR INDUSTRY PUBLISHER | | |
| 13a. STATE MARYLAND | | | 13b. COUNTY ANNE ARUNDEL | | 13c. CITY OR TOWN Severna Park | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 138 Round Bay Rd. 2146 | |
| 14 FATHER'S NAME FIRST MIDDLE LAST William Felder | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophie | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 216-10-3487 | | | 17 INFORMANT Arthur J. Judge (Same as #13) | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pulmonary fibrosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>many years</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>bronchiectasis</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/27</u> 19 <u>85</u> to <u>1/6</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>1/6</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>William Davidson MD</u> | | | | | DEGREE MD | | 22c. DATE SIGNED 1/6/86 | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) William Davidson | | | | | 22e. ADDRESS Mercy Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 1-9-86 | | 23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD | | | |
| 24 FUNERAL DIRECTOR NAME ROBERT BARRANCO | | | | | ADDRESS 495 RITCHIE HWY SEVERNA PK MD 2146 | | 25a. DATE REC'D. BY REGISTRAR JAN 10 1986 | | | |

MEDICAL CERTIFICATION

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

01239

1- FOR
STATE
REGISTRAR

038050

| | | | | | |
|---|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) ANN D. KAPLAN | | | 2a. DATE OF DEATH MONTH DAY YEAR 01-30-86 | | 2b. HOUR 10³⁰ A.M. |
| 3. SEX FEMALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR MAY 11, 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE STATE OR FOREIGN COUNTRY RUSSIA | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LEVINDALE HEBREW HOME | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | 12b. KIND OF BUSINESS OR INDUSTRY APT. 107 | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | 13c. CITY OR TOWN BALTIMORE | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 6310 GREENSPRING AVE. 21209 |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH DISKIN | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KATIE BELKIN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 216-48-0228 | | 17. INFORMANT MRS. ELINOR ADKMAN 10 FARMHOUSE CT. BALTO., MD 21208 | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CA PANCREAS WITH DUE TO, OR AS A CONSEQUENCE OF (b) wide spread metastases DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mths. |
|---|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.

| | | | | | |
|--|--|--|--|--|---|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-23-86 to 1-30-86 , that (I) (we) lost saw the deceased alive on 1-30-86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE B. ZANWIN | | DEGREE | | 22c. DATE SIGNED 1-30-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. ZANWIN | | 22e. ADDRESS Levinale Geriatric Cn | | BALTO 21215 | |

| | | | |
|--|----------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE FEB. 2, 1986 | 23c. NAME OF CEMETERY OR CREMATORY CHIZUK AMONO | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND |
| 24. FUNERAL DIRECTOR NAME ADDRESS SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE FEB 05 1986 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept for 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



Kaplan

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which spread techniques

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|--|---------------------------------------|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) PANAGIOTA A. KATSOUIS | | 2a. DATE OF DEATH MONTH DAY YEAR January 4, 1986 | | 2b. HOUR 5:43 P.M. | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 10, 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Greece | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. - Seamstress | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 3303 Mary Ave. 21214 |
| 14. FATHER'S NAME FIRST MIDDLE LAST Anthony Calos | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vasiliki Diakoumakos | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-36-2091 | | 17. INFORMANT ADDRESS Mr. Athan Katsoulis Same as #13e | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) no arrhythmias Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) congestive heart failure & cirrhosis PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) portal hypertension | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ~ 4 years 30 years |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 70a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF PLAIN IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 72a. I certify that (1) (this hospital) attended the deceased from 19 85 to 1 19 86 that (2) (we) last saw the deceased alive on 19 86 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (3) (we) (did) (did not) view the body after death. | | | | | |
| 72b. SIGNATURE <i>Nicholas Belitsos</i> | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 72c. DATE SIGNED 1/6/86 | |
| 72d. PHYSICIAN'S NAME (TYPE OR PRINT) Nicholas Belitsos, M.D. | | 72e. ADDRESS 20 E. Eager St. | | | |
| 73a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 73b. DATE 1-7-86 | | 73c. NAME OF CEMETERY OR CREMATORY St. Demetrios | |
| 73d. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. | | ADDRESS Baltimore, Md. | | 73e. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | |
| 74. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. | | ADDRESS Baltimore, Md. | | 75a. DATE REC'D. BY REGISTRAR JAN 6 1986 | |
| 75b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | 75c. REGISTRAR'S NAME [Name] | | | |

MEDICAL CERTIFICATION

29

BP

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

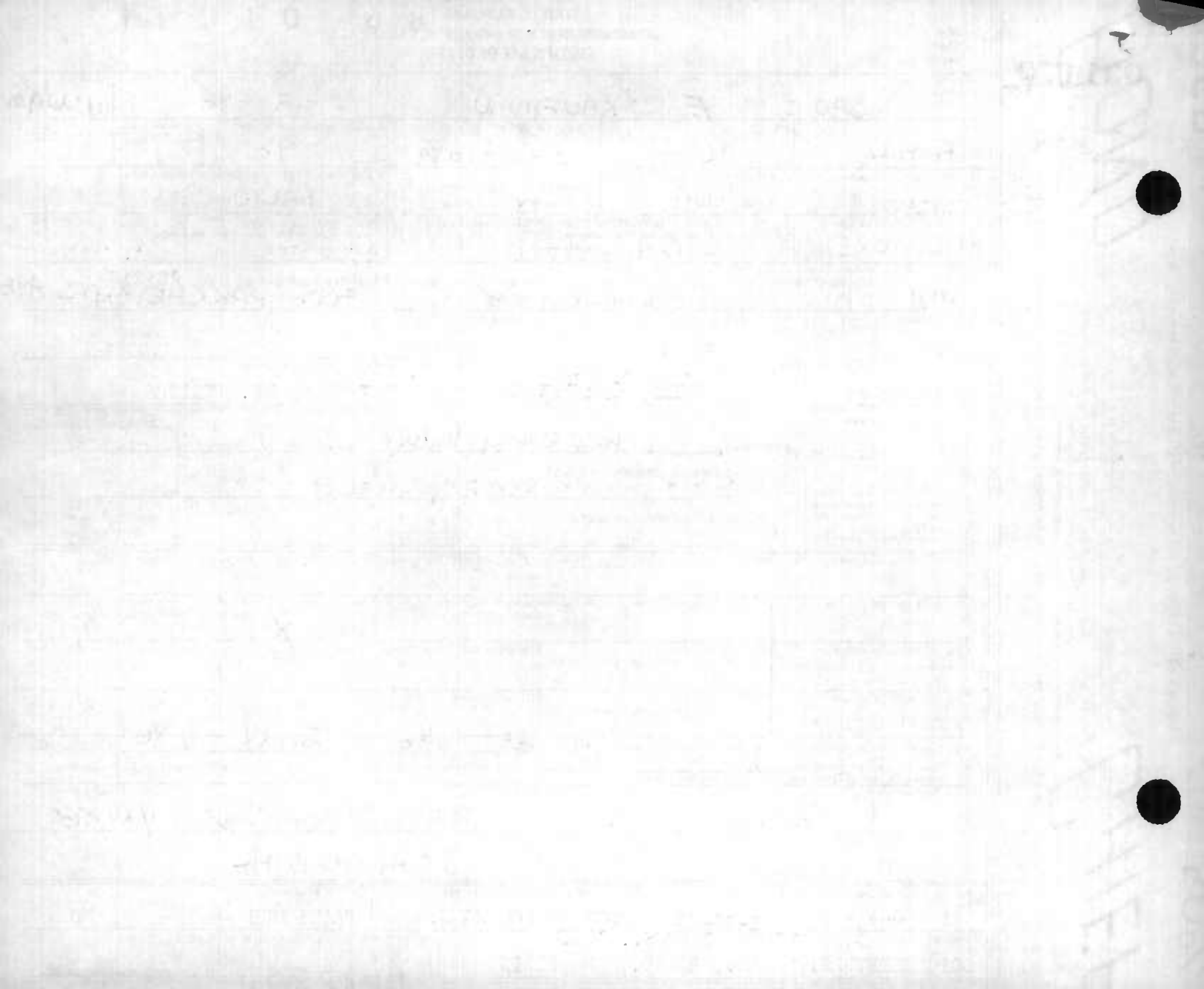
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| | | | | | |
|--|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SADIE F KAUFMAN | | | 2a. DATE OF DEATH MONTH DAY YEAR 1-24-86 | | 2b. HOUR 11:22AM |
| 3. SEX Female | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR 3-5-1889 | | 6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | 12b. KIND OF BUSINESS OR INDUSTRY AT HOME | |
| 13a. STATE MD | | 13b. COUNTY | 13c. CITY OR TOWN BALTIMORE | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 7006 PARK HEIGHTS AVE #21215 |
| 14. FATHER'S NAME FIRST MIDDLE LAST MAX FANTL | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HANNAH UNKNOWN | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | |
| 16b. SOCIAL SECURITY NO. XXXXXXXXXX | | 17. INFORMANT MRS. MAXINE ORLOVE 8309 BURNINGWOOD RD. #21208 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NO</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 23</u> , 19 <u>86</u> , to <u>Jan 24</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Jan 24</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE D Lally MD | | DEGREE | | 22c. DATE SIGNED 1/24/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) D LALLY | | 22e. ADDRESS SINAI HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE 1-26-86 | 23c. NAME OF CEMETERY OR CREMATORY OHEB SHALOM CONG. | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD | |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD., BALTO., MD 21215 | | | 25a. DATE REC'D. BY REGISTRAR JAN 29 1986 | | |
| 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



023039

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M
 BP _____
 DHMH - 17
 (VR A15 ME (5))

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 01242 | | | |
|---|---------|---------------------------------|---|---|----------------------------|--|---|--|--------------------------------------|--|----------|--|----------|
| 1- FOR STATE REGISTRAR | | | | | | | | | | 7a. DATE KNOWN OF DEATH | | XX MONTH DAY YEAR | 7b. HOUR |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Charles James Kavalesky Jr. | | | | | | | | | | 1-18 19 86 | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7c. DATE PRONOUNCED DEAD | 1-18 19 86 | 7d. HOUR | 7:32 p. M. | |
| Male | White | 4 2 55 | | 30 | | | | | | | | | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | MD | |
| Maryland | | | United States | | | | | | Baltimore City, | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | | University Hospital - STU | | | | Wall Finisher | | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS | | | |
| Maryland | | | | Carroll | | Sykesville | | YES | | 6037 Oakland Mill Rd. 21784 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | |
| Charles J. Kavalesky Sr. | | | | | | Betty Beardsley | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | |
| No | | | | 218-64-6439 | | Mrs. Betty Merenda | | 21784 | | 6037 Oakland Mill Road Sykesville, MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Blunt Trauma to Chest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| | | | | 5:45 M. 1-18 1986 | | passenger on motorcycle which struck fixed object and was ejected | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | road | | Old Court Rd. & Patapsco River Bridge, Balto. | | Co., Maryland | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | | |
| Dennis F. Smyth, M.D. | | | | M.D. Assistant | | | | 1-19-86 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | |
| Dennis F. Smyth, M.D. | | | | 111 Penn St., Balto., Md. 21201 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | | | 1/22/86 | | Lake View Mem. Park | | | | Sykesville Carroll MD | | | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Loring Byers Funeral Directors, Inc. | | | | JAN 21 1986 | | | | | | | | | |
| 8728 Liberty Road Randallstown, Maryland 21133 | | | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top portion. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 7a film G612 2/3/86 jab

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01243

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | | |
|--|--|--|---|--|-------------------------------|---|--|--|--|--|-------------------------------|--|
| 1 DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST CAROLINE E. KELLY | | | 2a DATE OF DEATH MONTH DAY YEAR 1 28 86 | | | 2b HOUR 7:45 AM | | | |
| 3 SEX Female | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR Feb. 2, 1913 | | 6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN) Mississippi | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | | |
| 10 CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Made Drapes | | | 12b KIND OF BUSINESS OR INDUSTRY Upholstery | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md | | | 13b COUNTY -- | | 13c CITY OR TOWN Baltimore | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS / ZIP CODE 413 W. 23rd Street 21211 | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Harry Boltas | | | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Boltas | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 563 26 5707 | | | 17 INFORMANT Patricia Mc Dermott | | | ADDRESS same | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC AND RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARDIOMYOPATHY WITH CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>ADULT ONSET DIABETES MELLITUS, (L) CVA WITH (R) HEMIPARESIS</u> | | | | | | | | | | | | |
| 19a DATE OF OPERATION --- | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED --- | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10 JAN</u> 19 <u>86</u> to <u>20 JAN</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>28 JAN</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE GAYLE A. HOPPER, MD | | | | | | DEGREE | | | 22c. DATE SIGNED 1/28/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) GAYLE A. HOPPER, MD | | | | | | 22e ADDRESS UNION MEMORIAL HSP, BALTIMORE, MD 21218 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 01/31/86 | | | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | | |
| 24 FUNERAL DIRECTOR NAME Burgee-Henss Funeral Home 3631 Falls Road 21211 | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | |

BP

JAN 29 1986

1. The first part of the report is a general
 description of the project and its objectives.
 2. The second part is a detailed description of
 the methodology used in the study.
 3. The third part is a description of the results
 of the study.
 4. The fourth part is a discussion of the results
 and their implications.
 5. The fifth part is a conclusion and a list of
 references.

017019

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 01244 | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HENRIETTA CECELIA KELLY | | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 11, 1986 | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH April 14, 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY) 89 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) England | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Edgewood Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LPN | | 12b. KIND OF BUSINESS OR INDUSTRY Medical | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Michael Kelly | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Isabella Coutts | | 16. STREET ADDRESS / ZIP CODE 510 Castle Drive 21212 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 212-32-3601 | | 17. INFORMANT ADDRESS Mrs. Isabel Seifert 214 Midhurst Rd. Baltimore, Md. 21212 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Arteriosclerotic Cardiovascular Disease</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>SEPT 17, 1985</u> to <u>JAN 11, 1986</u> , that (1) (we) lost saw the deceased alive on <u>JAN 11, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Walter R. Welzant, M.D.</u> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>JAN 13, 1986</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Walter R. Welzant, M.D. | | | | 22e. ADDRESS 6100 York Rd. Baltimore, Md. 21212 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Jan. 14, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge | | 23d. LOCATION Pikesville, Baltimore Co., Md. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212 | | | | 25a. DATE RECEIVED BY REGISTRAR JAN 14 1986 | | | |

010710



008191

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

01245

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|---|---|--|---|--|--|----------------------------------|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) | | | 2a DATE OF DEATH | | | 2b HOUR | | |
| JAMES M. KELLY | | | 01 01 86 | | | 1:59 P M | | |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH | 6 AGE (IN YEARS (LAST BIRTHDAY)) | | | 7 IF UNDER 1 YEAR | | |
| Male | White | 9 29 22 | 63 YRS. | | | MONTHS DAYS HOURS MIN. | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b CITIZEN OF WHAT COUNTRY? | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | U.S.A. | | BALTIMORE CITY MD. | | | | | |
| 10 CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | VETERANS ADMINISTRATION MEDICAL CENTER | | Custodian | | | Trucking | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13b COUNTY | | | 13c CITY OR TOWN | | |
| Maryland | | | A.A. | | | Pasadena | | |
| 14 FATHER'S NAME | | | 15 MOTHER'S MAIDEN NAME | | | | | |
| Alexander A. Kelly | | | Helen Mary Kelley | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b SOCIAL SECURITY NO | | | 17 INFORMANT | | |
| Yes | | | WW 11 | | | Helen M. Kelly | | |
| | | | 214 12 8149 | | | Same as 13e | | |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiopulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

Metastatic adenocarcinoma of lung

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

| | | | |
|---|---|---|--|
| 19a DATE OF OPERATION | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a AUTOPSY? | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | |
| 22a I certify that (I) (this hospital) attended the deceased from December 27, 19 85 to JANUARY 1, 19 86, that (we) lost saw the deceased alive on JANUARY 1, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b SIGNATURE | | DEGREE | 22c DATE SIGNED |
| Michael E. Kelly, MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 1-1-86 |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e ADDRESS | |
| Michael E. Kelly, MD | | 3900 Loch Raven Blvd. Balto., Md. 21218 | |

| | | | |
|---|----------|--|---|
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b DATE | 23c NAME OF CEMETERY OR CREMATORY | 23d LOCATION CITY OR TOWN COUNTY STATE |
| Burial | 1/6/86 | Baltimore National Cem | Baltimore === Md |
| 24 FUNERAL DIRECTOR | | 25a DATE RECEIVED BY REGISTRAR'S SIGNATURE | |
| George J. Gonce 4001 Ritchie Hwy Balto Md | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be kept with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal investigation may be notified.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

00812

00812



3

00812

00812

THE UNIVERSITY OF CHICAGO
LIBRARY
CHICAGO, ILL.

007130

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|---|---|------------------------------------|--|--|-----------------------------------|--|------------------------|----------|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR |
| MARY C. KELLY | | MARY | C. | KELLY | 1 | 2 | 86 | 4:20A | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| FEMALE | WHITE | 3 30 1900 | | | 85 | YRS. 1 00 | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Maryland | U.S.A. | | | | BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | St. Agnes Hospital | | | Homemaker | | | | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE | | | | |
| Maryland | | Baltimore | Arbutus | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 1130 Linden Avenue 21227 | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | 17. INFORMANT | | | | |
| A. Koontz | | UNAVAILABLE | | | 21228 | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | | | |
| NO | | 214-26-7441 | | | Mary E. Griffin 1236 Pleasant Valley Dr. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>atrial fibrillation - rapid ventricular response</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>cardiac arrhythmia</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hours</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED | |
| Sharon W. McClean | | | | | | | | 11/2/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | |
| Sharon W. McClean | | St. Agnes Hospital | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | |
| Burial | | 1/4/86 | Loudon Park Maus. | | Baltimore Maryland | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Hubbard Funeral Home, Inc. | | 4107 Wilkens Ave. | | | JAN 3 1986 | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN, The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial-transit permit. Then please remove carbon papers, sign and date 2. It should be filed with the 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

20% COTTON FIBER

MADE IN U.S.A.



003139



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|---|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Emil Kempf | | | 2a. DATE OF DEATH MONTH DAY YEAR January 28 1986 | | | 2b. HOUR 5 P M | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 18 1904 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 81 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver | | 12b. KIND OF BUSINESS OR INDUSTRY Hecht Co. | | |
| 13a. STATE Md. | | | 13b. COUNTY - | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 3217 Kenyon Ave. 21213 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Kempf | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Benesch | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | | 16b. SOCIAL SECURITY NO. Peacetime | | 17. INFORMANT ADDRESS Helen Kempf (wife) same address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Hypertension</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/11</u> , 19 <u>82</u> , to <u>1/28</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>1/28</u> , 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) did not view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>George Lowe</u> | | | DEGREE <u>MD</u> | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 1/29/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. George Lowe | | | 22e. ADDRESS 3703 Belair Rd. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 2/1/86 | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD. | | |
| 24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane, Balto. 21213 | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE <u>ma Gordon</u> | | |

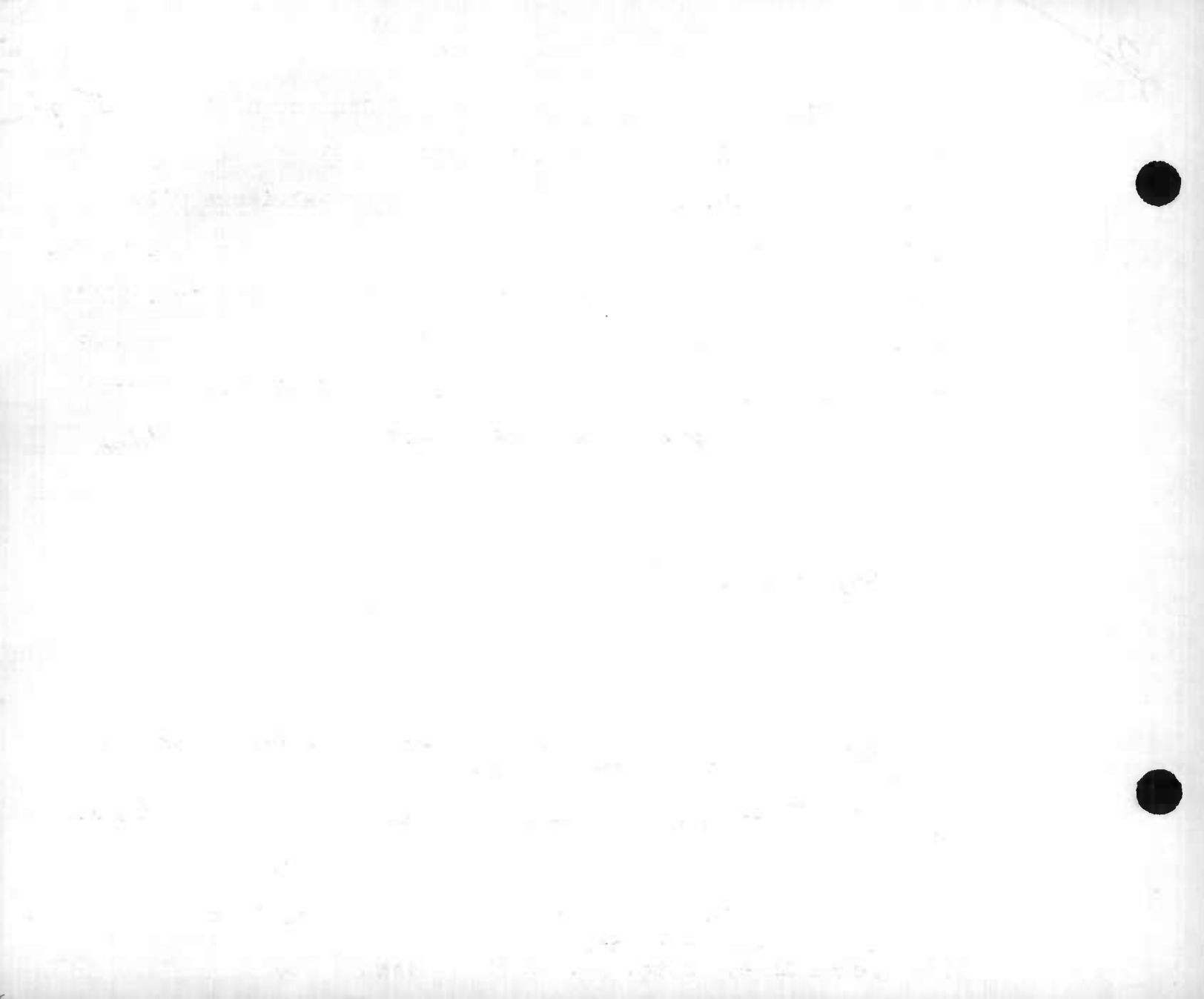
BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called and a post-mortem examination required.

20
035096



027020

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

01248

FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|---|--|---|---|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) ELSIE E KENEALY | | | 2a. DATE OF DEATH MONTH DAY YEAR 01/22/1986 | | | 2b. HOUR MIN. 3:10 P | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 2 23 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY) 88 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Charles Gen. Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sec'y | | 12b. KIND OF BUSINESS OR INDUSTRY School System | | |
| 13a. STATE Md. | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 2819 Mayfield Ave. 21213 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Louis Heiderich | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Connely | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | 16b. SOCIAL SECURITY NO. 216-28-5211 | | 17. INFORMANT ADDRESS Mary Jo Brennan 381 Centerhill Ave | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRO-VASCULAR DUE TO, OR AS A CONSEQUENCE OF (c) Accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7-10 days | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 01/20/86 19 86 to 01/22/86 19 86 , that (I) (we) last saw the deceased alive on 01/22/86 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE [Signature] | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 01/22/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. ANJARI | | | | | | 22e. ADDRESS North Charles Hospital Baltimore Md. 21218 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1-25-86 | | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 23 1986 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and forward them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

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Journal, Inc., Inc.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

007162

TO HOSPITAL OR ATTENDING PHYSICIAN: The undersigned certifies that the death certificate be associated within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/interment permit. Their please remove carbon duplicate and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, or other traumatic event, it must be certified.

| | | | | | | | | | | | | | | |
|--|--|---|--|---|---|---|--|--|--|--|--|--|------------------|--|
| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 01249 | | | | |
| 1- FOR STATE REGISTRAR | | | | | 1 DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE H. LAST KENNEDY | | | | | 2a DATE OF DEATH MONTH JANUARY DAY 2, YEAR 1986 | | | 2b HOUR 1:15 A M | |
| 3 SEX Female | | 4 RACE Black | | 5 DATE OF BIRTH MONTH May DAY 6, YEAR 1932 | | 6 AGE (IN YEARS LAST BIRTHDAY) 53 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C. | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | | | | |
| 10 CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MICRO BIOLOGY LAB | | 12b KIND OF BUSINESS OR INDUSTRY B.B.L | | | | | | |
| 13a STATE MARYLAND | | 13b COUNTY | | 13c CITY OR TOWN BALTIMORE | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS / ZIP CODE 1734 darley ave. 21213 | | | | | | |
| 14 FATHER'S NAME FIRST HAMPTON MIDDLE LAST FLOYD SR. | | | | 15 MOTHER'S MAIDEN NAME FIRST SOPHIE MIDDLE MAY LAST OLIVER | | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 216-28-7024 | | 17 INFORMANT ADDRESS RODNEY KENNEDY 1734 DARLEY AVE. 21213 | | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Overwhelming Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>hepatic insufficiency</u> | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.) | | 21f LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>11-28</u> 19 <u>85</u> , to <u>01-02</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>01-02</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b SIGNATURE <u>Walter N. Hernan Jr.</u> MD | | | | DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED <u>1/2/86</u> | | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>Walter N. Hernan Jr.</u> | | | | 22e ADDRESS <u>c/o Johns Hopkins Hospital</u> | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u> | | 23b DATE <u>1-6-86</u> | | 23c NAME OF CEMETERY OR CREMATORY <u>BALTIMORE</u> | | 23d LOCATION CITY OR TOWN <u>BALTIMORE</u> COUNTY <u>MARYLAND</u> STATE | | | | | | | | |
| 24 FUNERAL DIRECTOR NAME <u>WM.C. MARCH F/H INC.</u> ADDRESS <u>1101 E. NORTH AVE.</u> | | | | 25a DATE REC'D. BY REGISTRAR <u>JAN 3 1986</u> | | | | 25b REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | | | |

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01250

REG. NO.

| | | | | | |
|--|---|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) STEPHANIE R. Kern | | | 2a. DATE OF DEATH MONTH DAY YEAR 01 20 86 | | 2b. HOUR 12 ²⁰ A.M. |
| 3. SEX FEMALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR 7 - 18 - 54 | | 6. AGE (IN YEARS LAST BIRTHDAY) 31 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore City | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JUV. OF MD. Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None | | 12b. KIND OF BUSINESS OR INDUSTRY NONE |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD | | | 13c. CITY OR TOWN Silver Spring | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Robert R. Kern | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Muriel C. Dodd | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 213-66-1493 | | 17. INFORMANT ADDRESS ROBERT R. KERN (SAME AS #13) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Ischemic Brain Injury</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>Cardio Respiratory Arrest</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <u>Insulin Over Diabetes / 1/20 Reluctant / Diabetic Retinopathy</u> | | | | | |
| 19a. DATE OF OPERATION 12/86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Tracheostomy | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/24, 1985, to 1/20, 1986, that (I) (we) last saw the deceased alive on 1/20, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Lawrence F. Patrick MD | | DEGREE MD | | 22c. DATE SIGNED 1/20/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lawrence F. Patrick MD | | 22e. ADDRESS JUV. OF MD. Hosp | | 22f. SIGNATURE Don W. Surg. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | 23b. DATE JAN. 21, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREM. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE 16C. MD. | | 24. FUNERAL DIRECTOR NAME ADDRESS W. W. CHAMBERS CO. INC. SILVER SPR, MD. | | 25a. DATE REC'D. BY REGISTRAR JAN 28 1986 | |
| 25b. REGISTRAR'S SIGNATURE | | | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

027021

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|--|--|---|---|--|---|--|---|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) ANNA M. KERSCH | | | 2a. DATE OF DEATH MONTH DAY YEAR January 21, 1986 | | | 2b. HOUR M | | | | |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 26, 1908 | | 6 AGE (IN YEARS LAST BIRTHDAY) 77 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | |
| 10 CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7004 Old Harford Road | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Maryland | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS & ZIP CODE 7004 Old Harford Road 21234 | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Charles Vesely | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Korecky | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 215-32-8104 | | 17. INFORMANT ADDRESS Mr. J. Henry Kersch 2363 Northcliff Drive | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chemical DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Renal Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) Nephrosclerosis 2 1/2 HBP. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks. | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None | | | | | | | | | | |
| 19a. DATE OF OPERATION NA | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NA | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSE OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR AM MONTH DAY YEAR 11/22 19 85 | | 21c. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) NA | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (HOSPITAL, STREET, FACTORY, OFFICE, FARM, ETC.) NA | | 21f. LOCATION STREET CITY/TOWN COUNTY STATE 1/21 86 | | | | | | |
| 22a. I certify that (1) (the hospital) attended the deceased from 1/22 19 85 to 1/21 19 86 , that (1) was last saw the deceased alive on 1/22 19 85 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I was did not view the body after death.) | | | | | | | | | | |
| 22b. SIGNATURE Paul D. Light | | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/24/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul D. Light, M.D. | | | | 22e. ADDRESS University Hospital | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/24/86 | | 23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer | | 23d. LOCATION Baltimore Maryland | | STATE | | |
| 24 FUNERAL DIRECTOR Leonard J. Ruck, Inc. 5305 Harford Road 21214 | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 23 1986 | | 25b. REGISTRAR'S SIGNATURE John W. Wilson | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, pages 3 and 4 should be detached for use on the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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JAN 21 1966
U.S. DEPT. OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

January 21, 1966

TO: SAC, NEW YORK

FROM: SAC, BALTIMORE

BALTIMORE DIVISION

RE:

NY 100-100000

RE: [illegible]

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 01-11-83 BY SP-5 [illegible]

DATE 01-11-83 BY SP-5 [illegible]

RE: [illegible]

RE: [illegible]

RE: [illegible]

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RE: [illegible]

028057

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

01252

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|-------------------------|--|---|--|--------------------------|--|---------|--|----------|--|------|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | <input checked="" type="checkbox"/> MONTH | | DAY | | YEAR | | 2b. HOUR | | | | | |
| JEFFREY | | SCOTT | | KERT | | | | 1-20-86 | | | | | | | | M | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE IN YEARS | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | | 2d. HOUR | |
| Male | | White | | July 4, 1985 | | YRS. 6 | | MONTHS 16 | | HOURS | | MIN. | | 1-20-86 | | | | | | 9:24 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | XX | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | MD | |
| Maryland | | U.S.A. | | WIDOWED | | DIVORCED | | | | Baltimore City | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | |
| Baltimore | | Johns Hopkins Hospital | | Baby | | | | | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | | | | | |
| Md | | Balto. Co. | | Pikesville | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 605 Ralston Ave. 21208 | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | |
| Edward Lee Kert | | Melanie Kay Stubben | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | | | | | |
| No | | | | Edward Lee Kert | | 3401 Keswick Rd | | | | | | | | | | | | | | 21211 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | Head injuries | | | | | | | | | | | | | | | |
| | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

035113

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

01253

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|--|--|---|--|---|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frances Keyes (Keys) | | | 2a. DATE OF DEATH MONTH DAY YEAR January 30, 1986 | | 2b. HOUR M | | | | | | | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 6 12 12 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York, N.Y. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 401 EAST 25th Street Apt. 6B | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic | | | 12b. KIND OF BUSINESS OR INDUSTRY Domestic | | | |
| 13a. STATE Maryland | | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 401 E. 25th Street Apt. 6B 21218 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie Harmon | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-22-3728 | | 17. INFORMANT ADDRESS Dora D. Murray 2802 Ashland Avenue | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Cancer</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cervical Cancer</i> | | |
| | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF (c) | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Lymphedema</i> | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>July</i> 19 <i>85</i> to <i>Jan</i> 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>Jan 27</i> 19 <i>86</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) see the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE <i>David M. Jones</i> | | | DEGREE M.D. | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 1/31/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID M. JONES | | | 22e. ADDRESS JONES 1701 KINGS HOSR. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 2/4/86 | | 23c. NAME OF CEMETERY OR CREMATORY Mount Calvary Cem. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co, Md. | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Main Funeral Homes 1101 East North Avenue | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 31 1986 | | 25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | | |

MEDICAL CERTIFICATION

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

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| 1. DECEASED NAME (TYPE OR PRINT) VIRGINIA K. KINCAID | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 19 86 | | 2b. HOUR 5:22 A M |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 7 20 16 | | 6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | 7b. CITIZEN OF WHAT COUNTRY? U.S. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD | |
| 10. CITY OR TOWN OF DEATH Balto. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 16-East Bishop St. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Md. | | | 13b. COUNTY | 13c. CITY OR TOWN Balto. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST T. A. Kerns | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Barksdale | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 223-14-3358 | | 17. INFORMANT ADDRESS Ms. Blair Ashton 204 Blenheim Rd. Balto., Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic ca</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ca pharynx</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr 6 mos |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/18</u> , 19 <u>85</u> , to <u>Jan 19</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>12/18</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>William J. Kern</u> | | DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b. DATE 1/19/86 | | 23c. NAME OF CEMETERY OR CREMATORY | |
| 24. FUNERAL DIRECTOR NAME Anatomy Board | | ADDRESS Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR JAN 28 1986 | |
| | | 25b. REGISTRAR'S SIGNATURE <u>William J. Kern</u> | | | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate from pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause of death, a medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01255

REG. NO.

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|---|--|--|--|---|---|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MARY E. LAST King | | | 2a. DATE OF DEATH MONTH 1 DAY 20 YEAR 86 | | | 2b. HOUR 750 P.M. | | | |
| 3. SEX female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH 10 DAY 11 YEAR 02 | | 6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secour Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Maryland | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIGHT MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST MARY MIDDLE LAST BOONE | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | |
| 16b. SOCIAL SECURITY NO. 213-20-8108 | | | 17. INFORMANT ADDRESS Rosetta Jones 2232 Cedley St. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEVERE COPD & PULMONARY EDEMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCENDING AORTIC Aneurysm</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>days to weeks</u> <u>- long</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/16</u> , 19 <u>86</u> , to <u>1/20</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>1/20</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Dr. William M. Rubenstein</u> | | | DEGREE MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/21/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM R. RUBENSTEIN | | | 22e. ADDRESS 1940 W. Balto St Balto Md 21223 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1-24-86 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill | | 23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Md. | | |
| 24. FUNERAL DIRECTOR NAME Wm. C. Marchant Inc. | | | ADDRESS 1101 E. North Ave. | | | 25a. DATE REC'D. BY REGISTRAR JAN 22 1986 | | 25b. REGISTRAR'S SIGNATURE | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, file it by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

016061

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01256

REG. NO.

| | | | | | | | | | |
|---|--|---|--|--|--|--|--|---------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROSETTA KING | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 10 86 | | 2b. HOUR 10²⁵ A.M. | | | | |
| 3. SEX F | | 4. RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR 4 2 1895 | | 6. AGE (IN YEARS- LAST BIRTHDAY) 90 YRS MONTHS DAYS | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE City MD. | | | |
| 10. CITY OR TOWN OF DEATH BALT | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSP OF BALT. | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE MD | | | 13b. COUNTY BALT | | 13c. CITY OR TOWN BALT. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET ADDRESS / ZIP CODE 2102 E RIOME ST 21213 | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Johnson | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 216-12-2491 | | 17. INFORMANT Nellie White | | | ADDRESS 201 N. Broadway St. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS / CARDIO PULMONARY ARREST. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SEPSIS DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Ischemic CARDIOMYOPATHY, SENILE DEMENTIA | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/9/86 , 19 86 , to 1/10 , 19 86 , that (I) (we) lost saw the deceased alive on 1/10 , 19 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Vorperian | | DEGREE MD | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/10/86. | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) VORPERIAN V. | | 22e. ADDRESS SINAI HOSP OF BALTIMORE | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 1-14-86 | | 23c. NAME OF CEMETERY OR CREMATORY Mount Calvary | | 23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel MARYLAND | | | |
| 24. FUNERAL DIRECTOR WM. C. MARCH F/H INC. | | ADDRESS 1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR JAN 13 1986 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

100310

DEB

100310

100310

100310

022052

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please refile this certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 01257 | | | |
|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 15 86 | | | |
| 1. DECEASED NAME (TYPE OR PRINT) DOROTHY HEAPS KINNEAR | | | | 2b. HOUR 12 Noon | | | |
| 3. SEX F | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 09 09 25 | | 6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Lutherville | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 13e. STREET ADDRESS 125 Rodgefield Rd. 21093 | | | | 13f. CITY OR TOWN Lutherville, Md. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Lester Heaps | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pauline Fried | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 220-14-7559 | | 17. INFORMANT ADDRESS Vernon D. Kinnear Same | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphoma with Renal Failure DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 15 19 86 to Jan 15 19 86, that (I) (we) last saw the deceased alive on Jan 15 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Davis M. Hahn | | | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/15/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Davis M. Hahn | | | | 22e. ADDRESS 5801 Loch Raven Blvd 21239 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Jan. 19, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley | | 23d. LOCATION CITY OR TOWN COUNTY STATE Timonium, Balto. Co., Md. | |
| 24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212 | | | | 25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | | |

880350

CO

CO

39

CH



70

027002

Unknown #86-8

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 01258

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|-------------------------|---|--|---|--------------------------------|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Gregory P. Klemkowski | | | | 2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 1 20 19 86 | | | | 2b. HOUR 4:58 AM | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 10/19/1955 | 6. AGE (IN YEARS) LAST BIRTHDAY 30 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD 1 20 19 86 | | 2d. HOUR 4:58 AM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hanover St. & Cherry Hill Rd. Balto. Md. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Longshoreman | | 12b. KIND OF BUSINESS OR INDUSTRY Checker | |
| 13a. STATE Maryland | | | | 13b. COUNTY A.A.Co. | | 13c. CITY OR TOWN Brooklyn Park | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Jerry S. Klemkowski, Sr. | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan L. Wachter | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 216-62-8874 | | 17. INFORMANT 21225 1473 Woodall St. Mr. Jerry S. Klemkowski, Sr. Balto. Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 4:30xx 1-20- 1986 | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4:30xx 1-20- 1986 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver of auto/tractor trailer collision. | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Hanover St. & Cherry Hill Rd., Balto. City, MD | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE <i>Dennis F. Smyth</i> | | | | TITLE (SPECIFY) Assistant | | | | DATE SIGNED 1-20-86 | |
| EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. | | | | ADDRESS 111 Penn St., Balto., MD 212012 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/24/86 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. A.A.Co. Maryland | |
| 24. FUNERAL DIRECTOR NAME ADDRESS McCully Funeral Home, 130 E. Fort Ave. Balto. Md. 21230 | | | | 25a. DATE REC'D. BY REGISTRAR JAN 23 1986 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 2. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/B4
25MBP
DHMH - 17
(VR A15 ME (5))



ED

WATER

100% COTTON

027003

Unknown #86-9

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01259

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | | | |
|--|--|---|--|--|--|---|--|-----------------------------------|--|---|--|--------------------------|--|-------|--|----------|--|------|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | <input checked="" type="checkbox"/> MONTH | | DAY | | YEAR | | 2b. HOUR | | | | | |
| John | | R. | | Klemkowski | | | | 1 20 1986 | | | | | | | | A | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | | 2d. HOUR | |
| Male | | White | | 2/15/1967 | | 18 YRS. | | | | | | 1 20 1986 | | | | | | | | 4:58 A | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | | MD | |
| Maryland | | USA | | | | Baltimore City | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | |
| Baltimore | | Hanover St. & Cherry Hill Rd. | | Bartender | | | | | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | | | | | |
| Maryland | | ----- | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 21230 1473 Woodall St. Balto. Md. | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | |
| Jerry S. Klemkowski, Sr. | | Susan L. Wachter | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | | | | | |
| No | | 218-98-6495 | | Mr. Jerry S. Klemkowski, Sr. | | Same as 13 | | | | | | | | | | | | | | | |

| | | | |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I DEATH WAS CAUSED BY: | | | |
| 8121 IMMEDIATE CAUSE (a) <u>Cranio-cerebral trauma</u> | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | |
| (b) <u>DUE TO, OR AS A CONSEQUENCE OF</u> | | | |
| (c) <u></u> | | | |

| | | | | | |
|--|--|---|--|---|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 4:30xx 1-20- 1986 | | | | Passenger of auto/tractor trailer collision. | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| road | | Hanover St. & Cherry Hill Rd. | | Balto. City, MD | |

| | | | |
|--|--|--|--|
| 22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> and in my opinion | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> | |
| ACTUAL SIGNATURE <u>Dennis F. Smyth, M.D.</u> | | TITLE (SPECIFY) <u>Assistant</u> MEDICAL EXAMINER | |
| EXAMINER'S NAME (TYPE OR PRINT) <u>Dennis F. Smyth, M.D.</u> | | DATE SIGNED <u>1-20-86</u> | |
| ADDRESS <u>111 Penn St., Balto., MD 21201</u> | | | |

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>1/24/86</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Balto. A.A.Co. Maryland</u> | |
| 24. FUNERAL DIRECTOR NAME <u>McCully Funeral Home, 130 E. Fort Ave.</u> | | 25a. DATE REC'D. BY REGISTRAR <u>JAN 23 1986</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. OBTAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

030003

FOR COTTON

MAINTENANCE

017149

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01260

| | | | |
|--|--|--|---|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | |
| FIRST MIDDLE LAST EMILY KLIMES | | JANUARY 11 1986 11 86 4 20 P.M. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) |
| FEMALE | WHITE | MONTH DAY YEAR AUGUST 29 1907 | 78 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH |
| MD. | USA | | BALTIMORE CITY MD. |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
| BALTIMORE | UNION MEMORIAL HOSPITAL | HOMEMAKER | - |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. CITY OR TOWN | 13c. INSIDE CITY LIMITS? |
| 13a. STATE | | BALTIMORE | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| MD. | - | | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 13e. STREET ADDRESS / ZIP CODE | |
| FIRST MIDDLE LAST LOUIS F. LAPACEK | FIRST MIDDLE LAST Emilie Tavik | 830 W. 40th ST. 21211 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | |
| NO | 215-54-4890 | 2550 Old Kays Mill Rd. Finksburg Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Myotrophic Lateral Sclerosis</u> | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| - | - | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 10</u> , 19 <u>86</u> , to <u>Jan 11</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Jan 11</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | |
| 22b. SIGNATURE <u>Margaret M. Vaughan</u> DEGREE | | 22c. DATE SIGNED <u>11/11/86</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MARGARET M. VAUGHAN M.D.</u> | | 22e. ADDRESS <u>UNION MEMORIAL HOSPITAL</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
| BURIAL | 1/15/86 | BOHEMIAN NAT'L | BALTIMORE MD. |
| 24. FUNERAL DIRECTOR NAME <u>SCHIMUNEK FUNERAL HOME, INC.</u> | | 25a. DATE REC'D. BY REGISTRAR <u>JAN 14 1986</u> | |
| 2331 Brehms Lane, Balto. Md. 21213 | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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014125

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|---|--|--|--|---|--|--|
| 1. DECEASED NAME FIRST MIDDLE LAST Melvin Knellingbr | | | 2a. DATE OF DEATH MONTH DAY YEAR 1-7-86 | | 2b. HOUR 2:15 P.M. | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR 12-15-1913 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 72 yrs. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | 8. IF UNDER 24 HRS HOURS MIN. | | |
| 9. BIRTHPLACE (STATE OR FOREIGN) Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed | | |
| 12b. KIND OF BUSINESS OR INDUSTRY - | | 13a. STREET ADDRESS / ZIP CODE 3205 Kentucky Avenue 21213 | | | | |
| 13a. STATE Md. | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Knellinger | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Sager | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no Yes | | 16b. SOCIAL SECURITY NO. 215-07-9975 | | 17. INFORMANT ADDRESS 21213 Ruby Knellinger 3205 Kentucky Avenue | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Possible Aspiration</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 35 minutes | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>1) Candida Sepsis 2) History of incarcerated Hernia</u> | | | | | | |
| 19a. DATE OF OPERATION 12-31-85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Incarcerated Hernia | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR N.A. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) N.A. | | | | |
| 21d. INJURY OCCURRED N.A. WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N.A. | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE N.A. | | |
| 22a. I certify that (I) (person) attended the deceased from <u>12-25-85</u> , 19 <u>85</u> , to <u>1-7-86</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>1-7-86</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | | |
| 22b. SIGNATURE <u>J. Weiner</u> | | DEGREE MD | | 22c. DATE SIGNED 1-7-86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JEREMY WEINER | | 22e. ADDRESS Union Memorial Hospital 201 E. University Parkway 21218 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-10-86 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore Cem. | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md. | | 24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane, Balto., Md. 21213 | | | | |
| 25a. DATE REC'D. BY REGISTRAR JAN 10 1986 | | 75b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial request permit. Then please return carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.
IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



024038

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01262

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Knight Teresa | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 21 86 | | | 2b. HOUR 20 (M) | | | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR 3 10 42 | | 6. AGE (IN YEARS LAST BIRTHDAY) 43 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH County Balt. City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SH Sinai Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY Advertising | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE 1635 Parkman Avenue, 21230 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George R. Kraning | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Starry | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 217-40-8077 | | 17. INFORMANT ADDRESS Emory J. Knight, 1635 Parkman Avenue, 21230 | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) hypoglycemia + multiple infarct DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/05 , 19 85 , to 1/21 , 19 86 , that (I) (we) last saw the deceased alive on 1/21 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE N. Brookins Reddix | | | | DEGREE MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/21/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) N. Brookins Reddix | | | | 22e. ADDRESS Sinai Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/24/86 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc., 4107 Wilkens Ave. | | | | ADDRESS 21229 | | 25a. DATE REC'D. BY REGISTRAR JAN 22 1986 | | | |
| | | | | REGISTRAR'S SIGNATURE J. Gordon Riddle | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

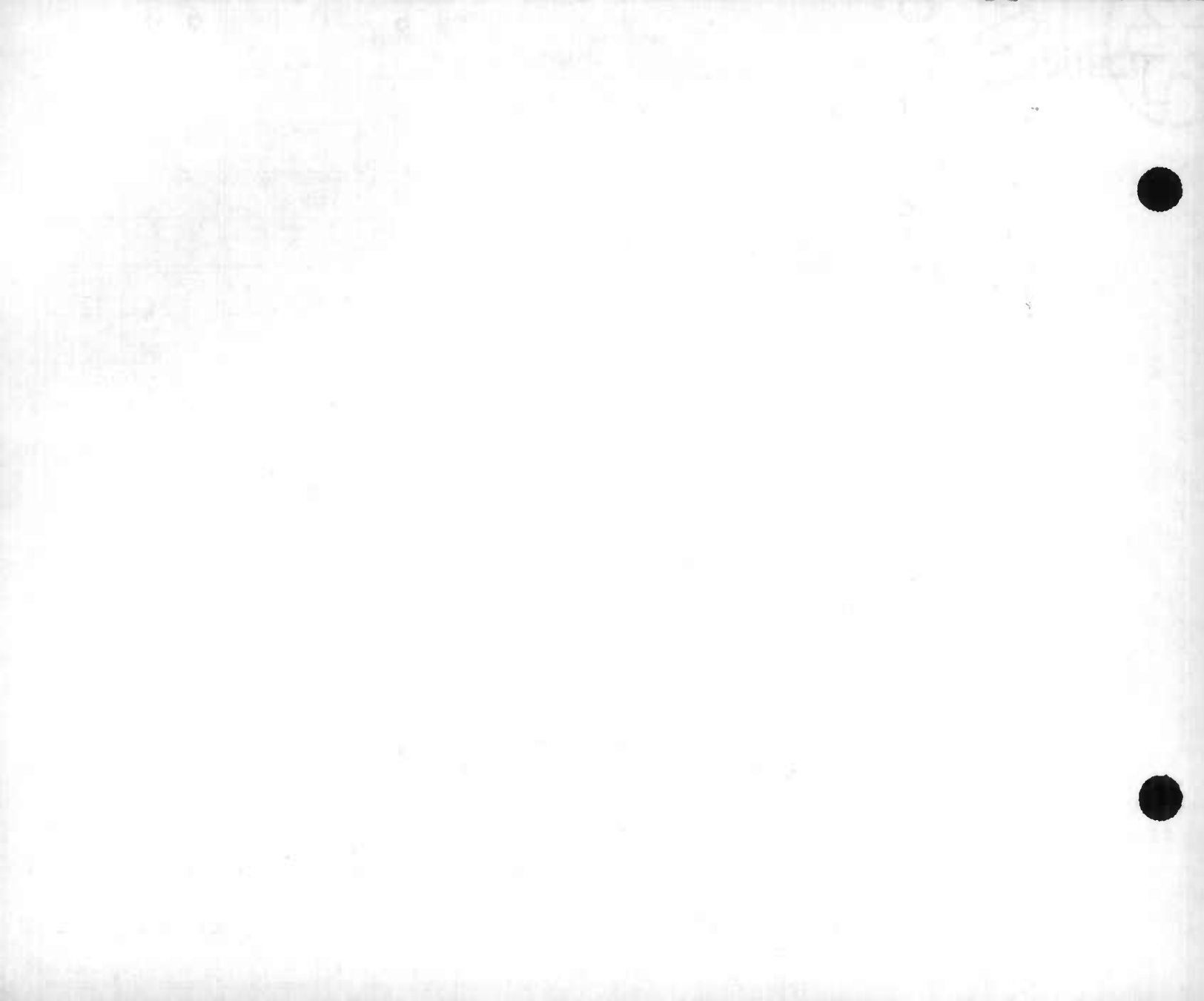
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01263

| | | | |
|---|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CONSTANCE ELIZABETH KNOCKET | | 2a. DATE OF DEATH MONTH DAY YEAR 1 16 86 | |
| 3. SEX FEMALE | | 2b. HOUR M | |
| 4. RACE BLACK | | 6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS. | |
| 5. DATE OF BIRTH MONTH DAY YEAR 12 09 1919 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. CAROLINA | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 12b. KIND OF BUSINESS OR INDUSTRY HOME | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2305 BRYANT AVENUE | | 13a. STREET ADDRESS / ZIP CODE BALTIMORE, MARYLAND 21217 | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | |
| 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOHN GRANT | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE JONES | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO. | | 16b. SOCIAL SECURITY NO. 217-20-9392 | |
| 17. INFORMANT Mr. RALPH L. KNOCKET | | 2305 BRYANT AVENUE BALTIMORE, MARYLAND 21217 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>WIDELY METASTATIC UNDIFFERENTIATED</u> DUE TO, OR AS A CONSEQUENCE OF <u>LARGE CELL CARCINOMA, LUNG</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 MONTHS</u> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b): <u>NONE</u> | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK NOT WHERE <input type="checkbox"/> AT WORK | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I (this hospital) attended the deceased from <u>10/17/85</u> to <u>1/17/86</u> , that (I (we) lost saw the deceased alive on <u>1/17</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) (they) did not view the body after death. | | | |
| 22b. SIGNATURE Victor G Vogel | | 22c. DATE SIGNED 1/16/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) VICTOR VOGEL | | 22e. ADDRESS 600 N. WOLFE ST, BALTIMORE 21205 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 1/20/1986 | |
| 23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEMORIAL PARK | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MARYLAND | |
| 24. FUNERAL DIRECTOR NAME NOTER & SONS FUNERAL HOME, INC. | | 25a. DATE REC'D. BY REGISTRAR JAN 24 1986 | |
| 25b. REGISTRAR'S SIGNATURE 2501 GWYNNS FALLS PKWY. BALTIMORE, MD..21216 | | | |



029131

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01264

REG. NO.

| | | | | | | | |
|--|--|---|---|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) JOSEPH KNOTT | | | 2a. DATE OF DEATH MONTH DAY YEAR 1-10-86 | | | 2b. HOUR 7:13p.m. | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 3 7 04 | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PROVIDENT HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 13e. STREET ADDRESS / ZIP CODE 3700 Liberty Hgts. Ave. 21215 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unkn. | | 16b. SOCIAL SECURITY NO. 911-24-1943 | | 17. INFORMANT Mr. Robert Neal | | ADDRESS 3700 Park Hgts. Ave. Balto., Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 9120 IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Aspiration DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. certify that (I) (this hospital) attended the deceased from 12/1/85 19 85 , to 1/10 19 86 , that (I) (we) lost saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE AD Silva | | DEGREE | | 22c. DATE SIGNED 1-10-86 | | 22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) ANTHONY A. DASILVA | | 22f. ADDRESS 2600 Liberty Ht. Ave. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b. DATE 1/14/86 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME Anatomy Board | | ADDRESS Balto., Md. | | 25. BY (TYPE OR PRINT) REGISTRAR'S SIGNATURE JAN 22 1986 | | | |

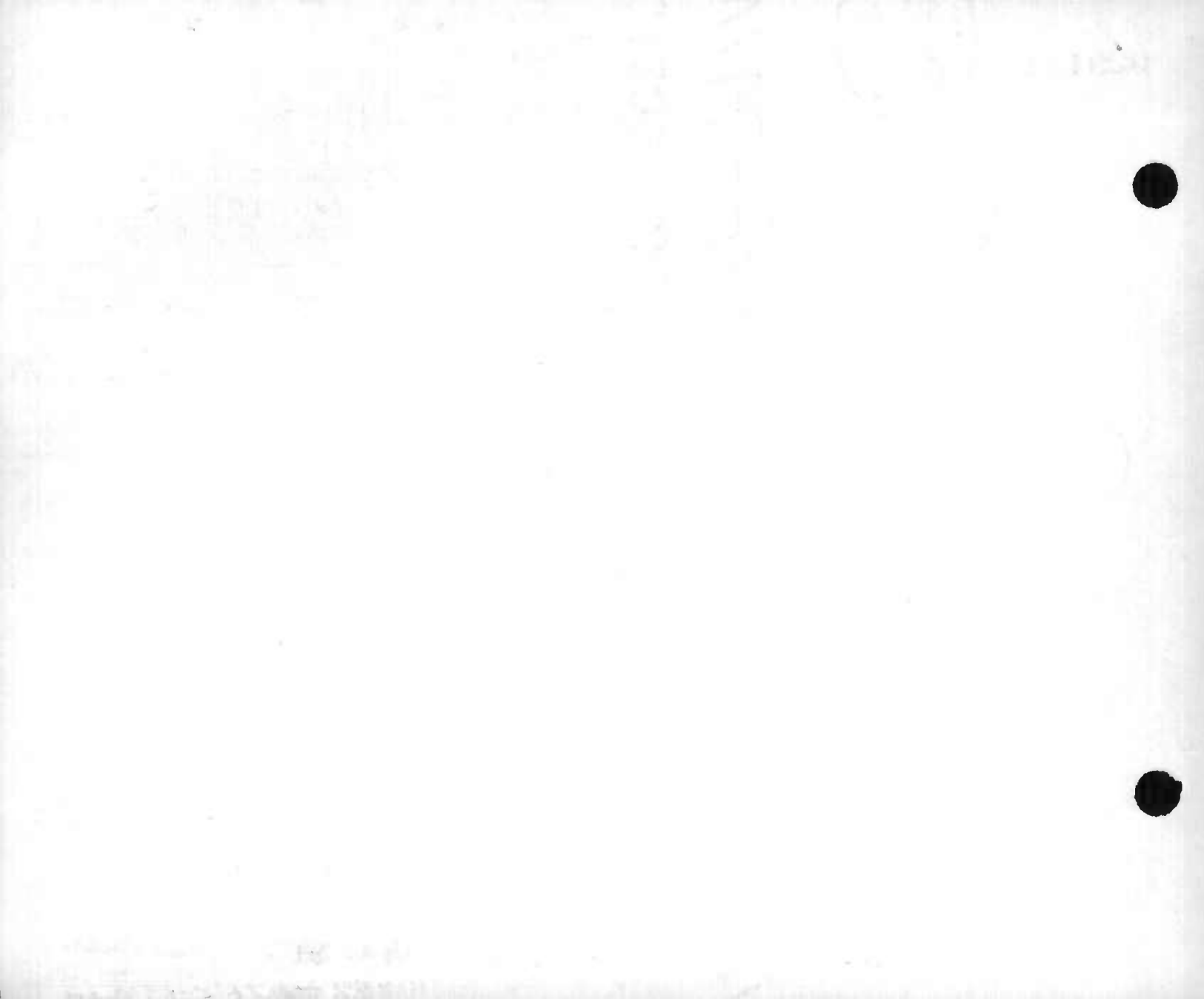
MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP



029086

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) SVEND J. KNUDSEN | | | 2a. DATE OF DEATH MONTH DAY YEAR January 25, 1986 | | | 2b. HOUR 5:00P M | | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 4 3 04 | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Denmark | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Home and Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Baker | | 12b. KIND OF BUSINESS OR INDUSTRY St. Agnes Hosp. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 524 N. Charles Street Apt 404 21201 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 547-26-0510 | | 17. INFORMANT ADDRESS Loretta Fitzsimmons 333 Yale Avenue 21229 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS DUE TO, OR AS A CONSEQUENCE OF (b) MALNUTRITION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) DEHYDRATION | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. a CHRONIC OBSTRUCTIVE PULMONARY DISEASE | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>DECEMBER 28 85</u> , to <u>January 25 19 86</u> , that (I) (we) last saw the deceased alive on <u>January 25 19 86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>G. Vellankaran MD</i> | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/25/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. VELLANKARAN MD | | | | 22e. ADDRESS Church Hospital, XXXXX . 100 N. Broadway, Balto, Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 1/27/86 | | 23c. NAME OF CEMETERY OR CREMATORY Security Process Crem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto. Md. | | | |
| 24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC. | | | | ADDRESS 4107 WILKENS AVE. | | 25a. DATE REC'D. BY REGISTRAR JAN 27 1986 | | 25b. REGISTRAR'S SIGNATURE <i>Robert R. ...</i> | |

MEDICAL CERTIFICATION

29

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01266

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|--|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FLORENCE R. KOPP | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 18 86 | | | 2b. HOUR 8:12 AM | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 4 9 11 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA MD. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MT VERNON CARE CNT | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |

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|---|--|--|--|--|--|---|--|--|---|--|--|---|--|--|
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | | | 13b. COUNTY Baltimore | | | 13c. CITY OR TOWN BALTIMORE | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE 1025 BRISTOL PLACE 21225 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Elksie P. Hoxman | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kate R. Messick | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 212-34-7708 | | | 17. INFORMANT ADDRESS Leonard Vickers Oxon Hill, Md. | | | | | | | | |

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|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Chronic obstructive lung disease, Diverticulosis | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
|---|--|---|--|

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|--|--|--|--|---|--|---|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic obstructive lung disease, Diverticulosis | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |

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|--|--|--|--|--|--|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3-1-85 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-3-86 to 1-18-86 , that (I) (we) last saw the deceased alive on 1-18-86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE S. AUJLA | | | | 22c. DATE SIGNED 1-19-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. AUJLA | | | | 22e. ADDRESS 5400 OLD COURT ROAD RANDALLSTOWN MD 21133 | |

| | | | | | | | |
|--|--|-----------------------------|--|------------------------------------|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b. DATE 1/18/86 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
|--|--|-----------------------------|--|------------------------------------|--|--|--|

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| 24. FUNERAL DIRECTOR NAME Messick Funeral Home | | ADDRESS Baltimore, Md. | | 25a. DATE REC'D. BY REGISTRAR JAN 28 1986 | | 25b. REGISTRAR'S SIGNATURE Jan Davidson-Horn | |
|---|--|----------------------------------|--|---|--|--|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|--|---|---|---|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| WILLIAM G KORN SR | | JANUARY 09, 1986 | | 2:10 P ^M | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| Male | White | May 9, 1920 | 64 YRS. | IF UNDER 72 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH | | |
| Maryland | U.S.A. | | BALTIMORE CITY MD. | | |
| 10 CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| BALTIMORE | JOHNS HOPKINS HOSPITAL | | Ret.-B.E.G. | | Gas Service |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE | |
| Md. | Baltimore | Parkville | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 3014 Parktowne Rd. 21234 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | |
| Joseph J. Korn | | Florence Wintz | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT ADDRESS | |
| yes | | WW II 219-01-9912 | | Viola M. Korn 3014 Parktowne Rd. 21234 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Respiratory arrest.</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 mths</u> |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial infarction</u> | | | | | <u>2 hrs.</u> |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metastatic small cell Ca (Lung)</u> | | | | | <u>2 mths.</u> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/30, 1985</u> , to <u>1/9, 1986</u> , that (I) (we) lost saw the deceased alive on <u>1/9, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE <u>Adman</u> | | 22c. DATE SIGNED <u>1/9/85</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ARIL P. INAM</u> | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>Jan. 13, 86</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u> | |
| 23d. FUNERAL DIRECTOR NAME <u>Leonard J. Ruck, Inc.</u> | | 23e. ADDRESS <u>5305 Harford Rd. 21214</u> | | 23f. LOCATION CITY OR TOWN COUNTY STATE <u>Balto. Md.</u> | |
| 24. FUNERAL DIRECTOR NAME <u>Leonard J. Ruck, Inc.</u> | | 24b. ADDRESS <u>5305 Harford Rd. 21214</u> | | 25a. DATE REC'D. BY REGISTRAR <u>JAN 13 1986</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01268

FOR
STATE
REGISTRAR **William Kossiakoff**

REG. NO.

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) William Kossiakoff | | | 2a. DATE OF DEATH MONTH January DAY 2 YEAR 1986 | | 2b. HOUR 7:00 P.M. |
| 3 SEX Male | 4 RACE White | 5. DATE OF BIRTH MONTH July DAY 4 YEAR 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS | IF UNDER 1 YEAR MONTHS 7 DAYS 1 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Med. Cen. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ship Sealer | | 12b. LINKING OF BUSINESS OR INDUSTRY Trade Assoc. |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | | 13b. COUNTY Balto. | 13c. CITY OR TOWN Balto. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST Alexander MIDDLE Kossiakoff LAST Kossiakoff | | | 15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Unknown LAST Unknown | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 212-01-8975 | | 17. INFORMANT ADDRESS Gregory Kossiakoff, 7409 Chesapeake Dr | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured Abdominal Aneurysm | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hours |
| DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension / Atherosclerotic Disease | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Cardiovascular disease | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Cardiovascular disease | | | | | |
| 19a. DATE OF OPERATION 1/2/86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured Aneurysm | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/2 , 19 86 , to 1/2 , 19 86 , that (I) (we) last saw the deceased alive on 1/2 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Pamela A. Lipsett MD | | | | 22c. DATE SIGNED 1/2/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Pamela A. Lipsett | | | | 22e. ADDRESS Francis Scott Key Hospital | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/6/86 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Trinity Russian Orth Cem., Balto., Md. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md. | | 24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. | | 25a. DATE REC'D. BY REGISTRAR JAN 3 1986 | |
| 25b. REGISTRAR'S SIGNATURE [Signature] | | 25c. ADDRESS 3331 Brehms Lane, Balto., Md. 21213 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

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001700



20X-COLLOR HIBB

CHIEF W. D. DODD

5 HAB

028093

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

01269

| | | | | | | | | | |
|---|--|--|--------------------|---|--|---|--|--|--------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) KOVALESKI | | FIRST Anna | MIDDLE Lais | LAST Kovaleski | 2a. DATE OF DEATH MONTH 1 DAY 20 YEAR 86 | | 2b. HOUR 530p M. | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH 12 DAY 27 YEAR 14 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY Balto. City | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 409 Angelsea Street 21224 | |
| 14. FATHER'S NAME FIRST Gustave MIDDLE Miller LAST Miller | | 15. MOTHER'S MAIDEN NAME FIRST Hermena MIDDLE ? LAST ? | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 110-10-9998 | | 17. INFORMANT ADDRESS Philip R. Kovaleski 409 Angelsea St. 21224 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) resp. failure DUE TO, OR AS A CONSEQUENCE OF (c) myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/4/86 , 19____, to 1/20/86 , 19____, that (I) (we) lost saw the deceased alive on 1/20/86 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Patricia C. Hsia | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 1/20/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) PATRICIA C Hsia | | 22e. ADDRESS FSKMC 4940 Eastern Ave | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-24-86 | | 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Eastwood Balto. Co., Md. | | | |
| 24. FUNERAL DIRECTOR NAME Charles S. Zeiler & Son Inc. | | | | ADDRESS 6224 Eastern Ave. | | 25a. DATE REC'D. BY REGISTRAR JAN 23 1986 | | 25b. REGISTRAR'S SIGNATURE | |

MEDICAL CERTIFICATION

19

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement for the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The detached page must be filed with the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

z. 1000 1000 1000

014046

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate from the file. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST STEVEN G. KRAWCZYK | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 8 86 | | | | 2b. HOUR 8-10 P.M. | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 2 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH 2712 Rueckert Ave. MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Rougher | | 12b. KIND OF BUSINESS OR INDUSTRY Steel Mill | |
| 13a. STATE Md. | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 2712 Rueckert Ave. 21214 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Stanislaus Krawczyk | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Stanislawa Matuszak | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-14-5722 | | 17. INFORMANT ADDRESS Anna Krawczyk same | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHF (Congestive Heart Failure) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SHOCK POSSIBLE SEPTIC DUE TO, OR AS A CONSEQUENCE OF (c) ACUTE LEUKEMIA | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11:55 pm 1986 to 1/8 8-10 pm 1986 , that (I) (we) last saw the deceased alive on 1/8 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Promod Duggal | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Promod DUGGAL | | | | 22e. ADDRESS Good Samaritan Hospital Baltimore MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-13-86 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. 5305 Harford Rd. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 10 1986 | | 25b. REGISTRAR'S SIGNATURE <i>Leonard J. Ruck</i> | | | |

011013

1910

white

Male

U.S.A.

Harvard

Baltimore

Good Samaritan Hospital

Manager

Steel Mill

Baltimore

2719 Rochester Ave.

New York

Continental

Secretary

no

111-10-1700

with 100 pages

same



Holy Redeemer

1-1-70

Barth

Baltimore

February 4, 1965, Inc. 2702 Harbor St.

JAN 25

1965

022046

F&M
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 6 0 1 2 7 1

| | | | | |
|--|--|--|--|--|
| 1. DECEASED NAME (a) <u>John C. Krebs, aka John Charles Louis Krebs</u> (TYPE OR PRINT) <u>Charles L Krebs Sr.</u> | | 2. DATE OF DEATH MONTH DAY YEAR <u>1-15-86</u> | | 2b HOUR <u>10:42 PM</u> |
| 1. SEX <u>male</u> | 4 RACE <u>Caucasian</u> | 5 DATE OF BIRTH MONTH DAY YEAR <u>6-2-97</u> | 6 AGE (IN YEARS LAST BIRTHDAY) <u>88</u> YRS. | # UNDER 1 YEAR MONTHS DAYS # UNDER 24 HRS. HOURS MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Penna</u> | 7b CITIZEN OF WHAT COUNTRY? <u>USA</u> | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD. | |
| 10 CITY OR TOWN OF DEATH <u>Baltimore City</u> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>SCUTA Baltimore General</u> | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Shoe Cutter</u> | 12b. KIND OF BUSINESS OR INDUSTRY <u>Shoe</u> |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <u>md</u> | 13b COUNTY <u>A.A.</u> | 13c CITY OR TOWN <u>Baltimore</u> | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e STREET ADDRESS / ZIP CODE <u>206 W. 6th Ave</u> 21225 |
| 14 FATHER'S NAME FIRST MIDDLE LAST <u>Theodore O. Krebs</u> | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Clara A. McGord</u> | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>Yes</u> | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>1920-1921</u> | 17 INFORMANT ADDRESS <u>Frances E. Krebs Same as 13e</u> | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarct</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | |
| 19a DATE OF OPERATION | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b SIGNATURE <u>Rhonda Richards</u> | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <u>1-15-86</u> | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>Rhonda Richards</u> | 22e ADDRESS <u>3001 S. Hancock</u> | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | 23b. DATE <u>1/18/86</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u> | 23d LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore A.A. Md</u> | |
| 24 FUNERAL DIRECTOR <u>George J. Gonce 4001 Ritchie Hwy Balto Md</u> | | 25a DATE REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE <u>JAN 20 1986</u> <u>[Signature]</u> | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

02301

THE BOARD OF DIRECTORS, JAMES H. HARRIS, JR., PRESIDENT

1954-1955

1956-1957

1958-1959

1960-1961

1962-1963

1964-1965

1966-1967

1968-1969

1970-1971

1972-1973

1974-1975

1976-1977

1978-1979

1980-1981

1982-1983

1984-1985

1986-1987

1988-1989

1990-1991

1992-1993

20% COTTON

THE BOARD OF DIRECTORS, JAMES H. HARRIS, JR., PRESIDENT

035063

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01272

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|---|--|---|--|---|---|--|--|--|-----------------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Patricia L Krinski | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 30 86 | | | 2b. HOUR 6:50 AM | | | | | |
| 3. SEX Female | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 02 15 1933 | | 6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AT Home | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY BALTIMORE 13c. CITY OR TOWN Towson | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 8207 YARBOROUGH ROAD 21204 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WALTER J. BRANNAN | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LORETTA M. GIES | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219289124 | | 17. INFORMANT ADDRESS FAMILY RECORDS | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/24 19 86, to 1/30 19 86, that (I) (we) last saw the deceased alive on 1/30 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Coburn V. Peterson MD | | | | | | DEGREE MD | | 22c. DATE SIGNED 1/30/86 | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Coburn V. Peterson | | | | | | 22e. ADDRESS Francis Scott Key Medical Center | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE FEB. 1, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Rossmore | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS EVANS CHAPEL OF CHIMES 4008 YORK ROAD | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 31 1986 | | 25b. REGISTRAR'S SIGNATURE John Davidson-Randall | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

020261

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01273

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|--|---|--|----------------------------------|
| 1 DECEASED NAME (TYPE OR PRINT) ALLEN E. KROH | | 2a DATE OF DEATH MONTH DAY YEAR 1 12 86 | | 2b HOUR 2:30 A.M. | |
| 3 SEX Male | 4 RACE White | 5 DATE OF BIRTH MONTH DAY YEAR July 16, 1903 | | 6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10 CITY OR TOWN OF DEATH Baltimore | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician | | 12b KIND OF BUSINESS OR INDUSTRY |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland | | 13b COUNTY Baltimore | 13c CITY OR TOWN Glen Arm | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST William Kroh | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Magdalena Wachsmuth | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b SOCIAL SECURITY NO. 213-07-8550 | | 17 INFORMANT ADDRESS Sophie C. Kroh - Same as #13e | |

| | | |
|---|--|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO, OR AS A CONSEQUENCE OF (b) End Stage Renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Hypertension DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH None 3 yrs 15 years |
|---|--|--|

| | | | |
|--|---|---|---|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: CHF, Colon CA | | | |
| 19a DATE OF OPERATION | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (this hospital) attended the deceased from Jan. 2 19 86 , to Jan 12 19 86 , that (we) last saw the deceased alive on Jan. 12 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b SIGNATURE Don Royan | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c DATE SIGNED 1/12/86 |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Royan | | 22e ADDRESS Good Samaritan Hosp. / Baltimore | |

| | | | |
|---|----------------------------|--|--|
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b DATE 1-15-86 | 23c NAME OF CEMETERY OR CREMATORY Dulaney Valley | 23d LOCATION CITY OR TOWN COUNTY STATE Cockeysville, Balto. Md. |
| 24 FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. | | ADDRESS 1050 York Rd. Towson, Md. 21204 | 25a DATE REC'D. BY REGISTRAR JAN 16 1986 |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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185 | 186 | 187 | 188 | 189 | 190 | 191 | 192 | 193 | 194 | 195 | 196 | 197 | 198 | 199 | 200 | 201 | 202 | 203 | 204 | 205 | 206 | 207 | 208 | 209 | 210 | 211 | 212 | 213 | 214 | 215 | 216 | 217 | 218 | 219 | 220 | 221 | 222 | 223 | 224 | 225 | 226 | 227 | 228 | 229 | 230 | 231 | 232 | 233 | 234 | 235 | 236 | 237 | 238 | 239 | 240 | 241 | 242 | 243 | 244 | 245 | 246 | 247 | 248 | 249 | 250 | 251 | 252 | 253 | 254 | 255 | 256 | 257 | 258 | 259 | 260 | 261 | 262 | 263 | 264 | 265 | 266 | 267 | 268 | 269 | 270 | 271 | 272 | 273 | 274 | 275 | 276 | 277 | 278 | 279 | 280 | 281 | 282 | 283 | 284 | 285 | 286 | 287 | 288 | 289 | 290 | 291 | 292 | 293 | 294 | 295 | 296 | 297 | 298 | 299 | 300 | 301 | 302 | 303 | 304 | 305 | 306 | 307 | 308 | 309 | 310 | 311 | 312 | 313 | 314 | 315 | 316 | 317 | 318 | 319 | 320 | 321 | 322 | 323 | 324 | 325 | 326 | 327 | 328 | 329 | 330 | 331 | 332 | 333 | 334 | 335 | 336 | 337 | 338 | 339 | 340 | 341 | 342 | 343 | 344 | 345 | 346 | 347 | 348 | 349 | 350 | 351 | 352 | 353 | 354 | 355 | 356 | 357 | 358 | 359 | 360 | 361 | 362 | 363 | 364 | 365 | 366 | 367 | 368 | 369 | 370 | 371 | 372 | 373 | 374 | 375 | 376 | 377 | 378 | 379 | 380 | 381 | 382 | 383 | 384 | 385 | 386 | 387 | 388 | 389 | 390 | 391 | 392 | 393 | 394 | 395 | 396 | 397 | 398 | 399 | 400 | 401 | 402 | 403 | 404 | 405 | 406 | 407 | 408 | 409 | 410 | 411 | 412 | 413 | 414 | 415 | 416 | 417 | 418 | 419 | 420 | 421 | 422 | 423 | 424 | 425 | 426 | 427 | 428 | 429 | 430 | 431 | 432 | 433 | 434 | 435 | 436 | 437 | 438 | 439 | 440 | 441 | 442 | 443 | 444 | 445 | 446 | 447 | 448 | 449 | 450 | 451 | 452 | 453 | 454 | 455 | 456 | 457 | 458 | 459 | 460 | 461 | 462 | 463 | 464 | 465 | 466 | 467 | 468 | 469 | 470 | 471 | 472 | 473 | 474 | 475 | 476 | 477 | 478 | 479 | 480 | 481 | 482 | 483 | 484 | 485 | 486 | 487 | 488 | 489 | 490 | 491 | 492 | 493 | 494 | 495 | 496 | 497 | 498 | 499 | 500 | 501 | 502 | 503 | 504 | 505 | 506 | 507 | 508 | 509 | 510 | 511 | 512 | 513 | 514 | 515 | 516 | 517 | 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| 685 | 686 | 687 | 688 | 689 | 690 | 691 | 692 | 693 | 694 | 695 | 696 | 697 | 698 | 699 | 700 | 701 | 702 | 703 | 704 | 705 | 706 | 707 | 708 | 709 | 710 | 711 | 712 | 713 | 714 | 715 | 716 | 717 | 718 | 719 | 720 | 721 | 722 | 723 | 724 | 725 | 726 | 727 | 728 | 729 | 730 | 731 | 732 | 733 | 734 | 735 | 736 | 737 | 738 | 739 | 740 | 741 | 742 | 743 | 744 | 745 | 746 | 747 | 748 | 749 | 750 | 751 | 752 | 753 | 754 | 755 | 756 | 757 | 758 | 759 | 760 | 761 | 762 | 763 | 764 | 765 | 766 | 767 | 768 | 769 | 770 | 771 | 772 | 773 | 774 | 775 | 776 | 777 | 778 | 779 | 780 | 781 | 782 | 783 | 784 | 785 | 786 | 787 | 788 | 789 | 790 | 791 | 792 | 793 | 794 | 795 | 796 | 797 | 798 | 799 | 800 | 801 | 802 | 803 | 804 | 805 | 806 | 807 | 808 | 809 | 810 | 811 | 812 | 813 | 814 | 815 | 816 | 817 | 818 | 819 | 820 | 821 | 822 | 823 | 824 | 825 | 826 | 827 | 828 | 829 | 830 | 831 | 832 | 833 | 834 | 835 | 836 | 837 | 838 | 839 | 840 | 841 | 842 | 843 | 844 | 845 | 846 | 847 | 848 | 849 | 850 | 851 | 852 | 853 | 854 | 855 | 856 | 857 | 858 | 859 | 860 | 861 | 862 | 863 | 864 | 865 | 866 | 867 | 868 | 869 | 870 | 871 | 872 | 873 | 874 | 875 | 876 | 877 | 878 | 879 | 880 | 881 | 882 | 883 | 884 | 885 | 886 | 887 | 888 | 889 | 890 | 891 | 892 | 893 | 894 | 895 | 896 | 897 | 898 | 899 | 900 | 901 | 902 | 903 | 904 | 905 | 906 | 907 | 908 | 909 | 910 | 911 | 912 | 913 | 914 | 915 | 916 | 917 | 918 | 919 | 920 | 921 | 922 | 923 | 924 | 925 | 926 | 927 | 928 | 929 | 930 | 931 | 932 | 933 | 934 | 935 | 936 | 937 | 938 | 939 | 940 | 941 | 942 | 943 | 944 | 945 | 946 | 947 | 948 | 949 | 950 | 951 | 952 | 953 | 954 | 955 | 956 | 957 | 958 | 959 | 960 | 961 | 962 | 963 | 964 | 965 | 966 | 967 | 968 | 969 | 970 | 971 | 972 | 973 | 974 | 975 | 976 | 977 | 978 | 979 | 980 | 981 | 982 | 983 | 984 | 985 | 986 | 987 | 988 | 989 | 990 | 991 | 992 | 993 | 994 | 995 | 996 | 997 | 998 | 999 | 1000 | 1001 | 1002 | 1003 | 1004 | 1005 | 1006 | 1007 | 1008 | 1009 | 1010 | 1011 | 1012 | 1013 | 1014 | 1015 | 1016 | 1017 | 1018 | 1019 | 1020 | 1021 | 1022 | 1023 | 1024 | 1025 | 1026 | 1027 | 1028 | 1029 | 1030 | 1031 | 1032 | 1033 | 1034 | 1035 | 1036 | 1037 | 1038 | 1039 | 1040 | 1041 | 1042 | 1043 | 1044 | 1045 | 1046 | 1047 | 1048 | 1049 | 1050 | 1051 | 1052 | 1053 | 1054 | 1055 | 1056 | 1057 | 1058 | 1059 | 1060 | 1061 | 1062 | 1063 | 1064 | 1065 | 1066 | 1067 | 1068 | 1069 | 1070 | 1071 | 1072 | 1073 | 1074 | 1075 | 1076 | 1077 | 1078 | 1079 | 1080 | 1081 | 1082 | 1083 | 1084 | 1085 | 1086 | 1087 | 1088 | 1089 | 1090 | 1091 | 1092 | 1093 | 1094 | 1095 | 1096 | 1097 | 1098 | 1099 | 1100 | 1101 | 1102 | 1103 | 1104 | 1105 | 1106 | 1107 | 1108 | 1109 | 1110 | 1111 | 1112 | 1113 | 1114 | 1115 | 1116 | 1117 | 1118 | 1119 | 1120 | 1121 | 1122 | 1123 | 1124 | 1125 | 1126 | 1127 | 1128 | 1129 | 1130 | 1131 | 1132 | 1133 | 1134 | 1135 | 1136 | 1137 | 1138 | 1139 | 1140 | 1141 | 1142 | 1143 | 1144 | 1145 | 1146 | 1147 | 1148 | 1149 | 1150 | 1151 | 1152 | 1153 | 1154 | 1155 | 1156 | 1157 | 1158 | 1159 | 1160 | 1161 | 1162 | 1163 | 1164 | 1165 | 1166 | 1167 | 1168 | 1169 | 1170 | 1171 | 1172 | 1173 | 1174 | 1175 | 1176 | 1177 | 1178 | 1179 | 1180 | 1181 | 1182 | 1183 | 1184 | 1185 | 1186 | 1187 | 1188 | 1189 | 1190 | 1191 | 1192 | 1193 | 1194 | 1195 | 1196 | 1197 | 1198 | 1199 | 1200 | 1201 | 1202 | 1203 | 1204 | 1205 | 1206 | 1207 | 1208 | 1209 | 1210 | 1211 | 1212 | 1213 | 1214 | 1215 | 1216 | 1217 | 1218 | 1219 | 1220 | 1221 | 1222 | 1223 | 1224 | 1225 | 1226 | 1227 | 1228 | 1229 | 1230 | 1231 | 1232 | 1233 | 1234 | 1235 | 1236 | 1237 | 1238 | 1239 | 1240 | 1241 | 1242 | 1243 | 1244 | 1245 | 1246 | 1247 | 1248 | 1249 | 1250 | 1251 | 1252 | 1253 | 1254 | 1255 | 1256 | 1257 | 1258 | 1259 | 1260 | 1261 | 1262 | 1263 | 1264 | 1265 | 1266 | 1267 | 1268 | 1269 | 1270 | 1271 | 1272 | 1273 | 1274 | 1275 | 1276 | 1277 | 1278 | 1279 | 1280 | 1281 | 1282 | 1283 | 1284 | 1285 | 1286 | 1287 | 1288 | 1289 | 1290 | 1291 | 1292 | 1293 | 1294 | 1295 | 1296 | 1297 | 1298 | 1299 | 1300 | 1301 | 1302 | 1303 | 1304 | 1305 | 1306 | 1307 | 1308 | 1309 | 1310 | 1311 | 1312 | 1313 | 1314 | 1315 | 1316 | 1317 | 1318 | 1319 | 1320 | 1321 | 1322 | 1323 | 1324 | 1325 | 1326 | 1327 | 1328 | 1329 | 1330 | 1331 | 1332 | 1333 | 1334 | 1335 | 1336 | 1337 | 1338 | 1339 | 1340 | 1341 | 1342 | 1343 | 1344 | 1345 | 1346 | 1347 | 1348 | 1349 | 1350 | 1351 | 1352 | 1353 | 1354 | 1355 | 1356 | 1357 | 1358 | 1359 | 1360 | 1361 | 1362 | 1363 | 1364 | 1365 | 1366 | 1367 | 1368 | 1369 | 1370 | 1371 | 1372 | 1373 | 1374 | 1375 | 1376 | 1377 | 1378 | 1379 | 1380 | 1381 | 1382 | 1383 | 1384 | 1385 | 1386 | 1387 | 1388 | 1389 | 1390 | 1391 | 1392 | 1393 | 1394 | 1395 | 1396 | 1397 | 1398 | 1399 | 1400 | 1401 | 1402 | 1403 | 1404 | 1405 | 1406 | 1407 | 1408 | 1409 | 1410 | 1411 | 1412 | 1413 | 1414 | 1415 | 1416 | 1417 | 1418 | 1419 | 1420 | 1421 | 1422 | 1423 | 1424 | 1425 | 1426 | 1427 | 1428 | 1429 | 1430 | 1431 | 1432 | 1433 | 1434 | 1435 | 1436 | 1437 | 1438 | 1439 | 1440 | 1441 | 1442 | 1443 | 1444 | 1445 | 1446 | 1447 | 1448 | 1449 | 1450 | 1451 | 1452 | 1453 | 1454 | 1455 | 1456 | 1457 | 1458 | 1459 | 1460 | 1461 | 1462 | 1463 | 1464 | 1465 | 1466 | 1467 | 1468 | 1469 | 1470 | 1471 | 1472 | 1473 | 1474 | 1475 | 1476 | 1477 | 1478 | 1479 | 1480 | 1481 | 1482 | 1483 | 1484 |
|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-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020265

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|---|---|---|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Stephen Joseph Kron | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 12 86 | | 2b. HOUR 5:30pm | | | | |
| 3 SEX male | | 4 RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR 8 27 03 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Prof of Music | | 12b. KIND OF BUSINESS OR INDUSTRY Self employe | |
| 13. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? 13e. STREET ADDRESS / ZIP CODE MD Baltimore Catonsville YES NO 1 Delray Avenue 21228 | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Stephen Kron | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 213-32-7438 | | 17. INFORMANT ADDRESS Elfrieda Kron same as # 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Diffuse Histiocytic Lymphoma DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/1/86 to 1/11/86 , that (I) (we) last saw the deceased alive on 1/11/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE David Jung MD | | | | DEGREE MD | | | | 22c. DATE SIGNED 1/12/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) David Jung, MD | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-16-86 | | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City MD | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS MacNabb Funeral Home Catonsville, MD | | | | 25a. DATE REC'D. BY REGISTRAR JAN 16 1986 | | 25b. REGISTRAR'S SIGNATURE John Davidson | | | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be submitted to the

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the law, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP _____

020503

100% COTTON

CHIEFMAN

010005

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified.

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01275

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) PAUL N.M.I. KRYSOWATY Sr. | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 6 86 | | 2b. HOUR 7 45 AM |
| 3. SEX Male | 4. RACE Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR 1-31-17 | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) U.S.A. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE City MD. | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE CITY | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Auto Salesman | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY A.A. | | | 13c. CITY OR TOWN | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Michael Kryswaty | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Jaszczemska | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO 215-01-1512 | | 17. INFORMANT ADDRESS Mary Kryswaty same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) MASSIVE HEMOPTYSIS & CEREBRAL ANOXIA DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE 25 days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION - | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED - | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/11 19 85, to 1/6 19 86, that (I) (we) last saw the deceased alive on 1/6 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE W.A. JIRANEK | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/6/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) W.A. JIRANEK | | 22e. ADDRESS UNION MEMORIAL HOSP. BALTIMORE, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-9-86 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cem. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore A.A. MD | | 23e. DATE REC'D. BY REGISTRAR | | | |
| 24. FUNERAL DIRECTOR NAME McCurly Funeral Homes | | ADDRESS 237 E. Patapsco Ave. Baltimore, MD | | 25. REGISTRAR'S SIGNATURE JAN 5 8 1986 | |

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035131

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01276

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | | | | | |
|--|--|---|--|---|---------------------|--|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) STEWART HAMILTON KUHN | | | 2a. DATE OF DEATH MONTH DAY YEAR 01/28/86 | | 2b. HOUR 12:30pm | | | | | | | | | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 11 24 15 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Fire Fighter | | 12b. KIND OF BUSINESS OR INDUSTRY Baltimore City | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Arbutus | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 3300 Benson Ave. "304" 21227 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOHN HAMILTON | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MINNIE Fourth Somers | | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WW II | | | | 16b. SOCIAL SECURITY NO 215-03-4336 | | 17. INFORMANT Marie C. Kuhn 3300 Benson Ave. "304" 21227 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Obstructive Pulmonary Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>1/12/86</u> , 19 <u>86</u> , to <u>Jan 28</u> , 19 <u>86</u> , that (1) (we) lost saw the deceased alive on <u>Jan 28</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Robert E. Dupree, Jr.</u> MD | | | | | | DEGREE MD | | | | 22c. DATE SIGNED 1/28/86 | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert E. Dupree, Jr. MD | | | | | | 22e. ADDRESS St. Agnes Hospital | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1/31/86 | | | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge mem. Pk. Elkridge | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Howard Md. | | | | | | |
| 24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave. | | | | | | ADDRESS 21229 | | 25a. DATE REC'D. BY REGISTRAR JAN 31 1986 | | 25b. REGISTRAR'S SIGNATURE <u>Howard M. Howell</u> | | | | | |

MEDICAL CERTIFICATION

279

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) HELEN M. KURSCH | | | 2a. DATE OF DEATH MONTH DAY YEAR 01 21 86 | | | 2b. HOUR 9:00 A.M. | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 3 16 14 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD. | | | |
| 10. CITY OR TOWN OF DEATH City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1109 Nanticoke Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY --- | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | 13b. CITY OR TOWN Baltimore | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE 1109 Nanticoke Street, 21230 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Hefferhan | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Kelly | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 218-74-7431 | | 17. INFORMANT ADDRESS 21230 Frank R. Kursch, 1109 Nanticoke St., | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF <u>RHEUMATIC HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 510 85 121 86 | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/14</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Kuan-yu Huang M.D. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 22c. DATE SIGNED 1/21/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) KUAN G - YEN HUANG | | | | 22e. ADDRESS 517 SCOTT ST BALTO MD 21230 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/24/86 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc., 4107 Wilkens Ave. | | | | 25a. DATE REC'D. BY REGISTRAR 21229 JAN 22 1986 | | 25b. REGISTRAR'S SIGNATURE Jha Davidson-Randall | | | |

MEDICAL CERTIFICATION

99

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be certified at once.

020019

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01278

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|--|--|---|---|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) WILLIE M. KWIETYSKI | | | 2a. DATE OF DEATH MONTH DAY YEAR 1-8-1986 | | | 2b. HOUR 10:00 A.M. | |
| 3. SEX FEMALE | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 5-12-02 | | 6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager | |
| 12b. KIND OF BUSINESS OR INDUSTRY Clothing House | | 13a. STREET ADDRESS / ZIP CODE 888 W. LOMBARD STREET 21201 | | | | | |
| 13b. STATE MARYLAND | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 888 W. LOMBARD STREET 21201 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST MITCHELL, JAMES | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 385129392 | | 16c. INFORMANT J. L. Meehan Aff W. Lombard St. 21201 | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) RESPIRATORY DISTRESS - CARDIAC DISTRESS

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) BRONCHOPNEUMONIA

DUE TO, OR AS A CONSEQUENCE OF

(c) CHRONIC RENAL FAILURE

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

COPD (chronic obstructive pulmonary disease), Hypertension, Liver abscess

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION — | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/30</u> , 19 <u>85</u> , to <u>1/8</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>1/8</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>[Signature]</u> | | | | DEGREE | | 22c. DATE SIGNED 1/8/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RONY PORODOMINSKY | | | | 22e. ADDRESS 3001 HANNOVER ST. BALTIMORE, MARYLAND | | | |

| | | | | | | | |
|--|--|------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (TYPE) | | 23b. DATE 1-11-1986 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, Gt. Co. Md. | |
| 24. FUNERAL DIRECTOR Name John J. Connor, Inc. 901 Hallers St. | | | | 25a. DATED AND BY REGISTRAR 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please attach this certificate to the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, event, the medical examiner must be notified at once.

BP.

036170

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01279

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Katherine Virginia Labuda | | | 2a. DATE OF DEATH MONTH DAY YEAR January 27, 1986 | | 2b. HOUR M |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 8 29 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ft. Howard Hospital Worker | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Ft. Howard | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frank J. McVey | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine P. Baker | | 13e. STREET ADDRESS / ZIP CODE 9202 Howard Avenue 21052 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-07-5771 | | 17. INFORMANT ADDRESS Joseph A. Labuda, Jr. Same as 13e | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD and CHF</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>2 years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>John V. Conway, M.D.</u> | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/29/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) John V. Conway, M.D. | | 22e. ADDRESS 3401 Dundalk Avenue 21222 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 1/31/1986 | 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | |
| 24. FUNERAL DIRECTOR NAME Duda-Ruck, INC. | | ADDRESS 7922 Wise Avenue Dundalk, Maryland 21222 | | 25a. DATE REC'D. BY REGISTRAR FEB 03 1986 | 25b. REGISTRAR'S SIGNATURE <u>Shia Davidson-Randall</u> |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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041077

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01280

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|--|--|--|--|--|----------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Rush Leo Lacey, Jr. | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 24 86 | | 2b. HOUR 5 30 AM | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 5 27 40 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 45 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANCIS Scott Key Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Janitor | | 12b. KIND OF BUSINESS OR INDUSTRY Sanatoria | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN MD. BALT. BALT. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 248 S. Conkley St 1224 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Rush Leo Lacey | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cecelia Heintz | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) No | | 17. SOCIAL SECURITY NO. 220-36-2254 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) GI bleed DUE TO, OR AS A CONSEQUENCE OF (c) AIDS | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/15 , 19 86 , to 1/24 , 19 86 , that (I) (we) lost saw the deceased alive on 1/24 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE B. Massay | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/24/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. Massay, M.D. | | 22e. ADDRESS ESH | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL Cremation | | 23b. DATE 1/29/86 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY Suitland P.G. MD. | |
| 24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel | | ADDRESS Annapolis, MD. | | 25a. DATE RECD. BY REGISTRAR FEB 06 1986 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

MEDICAL CERTIFICATION

29

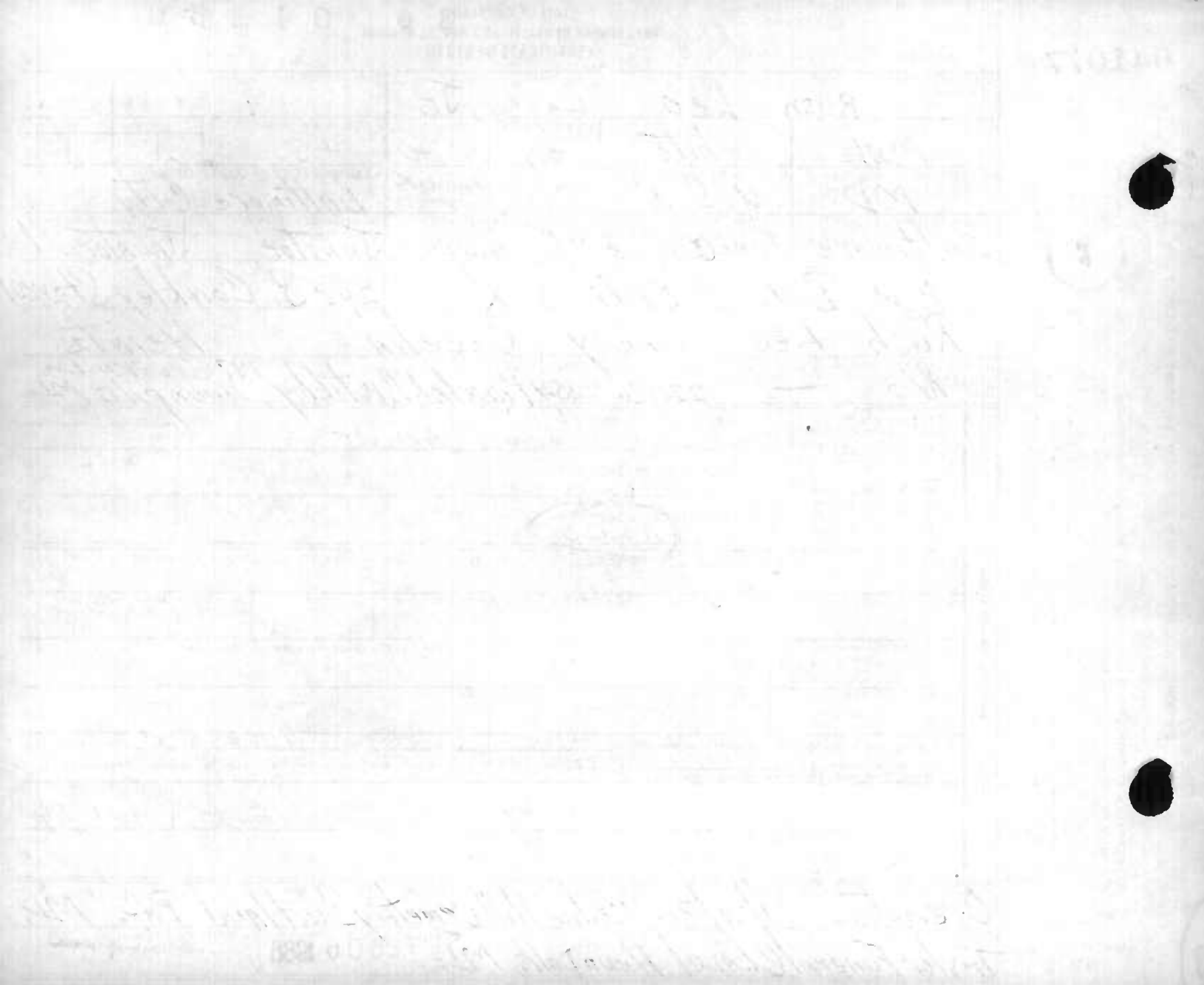
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



017111

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01281

REG. NO.

| | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) GLA DYS | | | FIRST MIDDLE LAST LACKS | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 12 86 | | | 2b. HOUR 11:40 a.m. | | |
| 3. SEX F | | | 4. RACE B | | | 5. DATE OF BIRTH MONTH DAY YEAR 2 2 31 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va. | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH City MD. | | |
| 10. CITY OR TOWN OF DEATH Balti | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cashier | | | 12b. KIND OF BUSINESS OR INDUSTRY Govt. | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md. | | | 13c. CITY OR TOWN Balti | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE 108 Carver Rd. 21222 | | |
| 14a. FATHER'S NAME FIRST MIDDLE LAST James E. Marshall | | | 14b. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah V. Tyree | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah V. Tyree | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 226-34-7419 | | | 17. INFORMANT ADDRESS Energic Lacks 108 Carver Rd. 21222 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adult Respiratory Distress Syndrome DUE TO, OR AS A CONSEQUENCE OF (b) MULTIPLE MYELOMA DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/17/85 to 1/12/86, that (I) (we) lost saw the deceased alive on 1/12/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE T. Emanuele | | | | | | DEGREE MD | | | 22c. DATE SIGNED 1/12/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) TULLIO EMANUELE, MD | | | | | | 22e. ADDRESS 5601 LOCH RAVEN BLVD BALTO, MD 21239 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1-17-86 | | | 23c. NAME OF CEMETERY OR CREMATORY Holly Hills | | | 23d. LOCATION City or Town County State Balti Md. | | |
| 24. FUNERAL DIRECTOR NAME Jas. A. Morton & Sons | | | | | | ADDRESS 1701 Laurens St. | | | 25a. DATE REC'D BY REGISTRAR JAN 14 1986 | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial or final disposition. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director for 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, signs any injury, or other traumatic event, the medical examiner must be notified at once.

028080

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01282

REG. NO.

| | | | | |
|---|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FRANK J. LACORTE | | 2a. DATE OF DEATH MONTH DAY YEAR JAN. 20, 1986 | | 2b. HOUR 10:00A _M |
| 3. SEX MALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR SEPT 3, 1926 | | 6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PATH. LAB. | 12b. KIND OF BUSINESS OR INDUSTRY JOHNS HOPKINS |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| FATHER'S NAME FIRST MIDDLE LAST J. Jerome LACORTE | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine DiVerdi | | |
| 14a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 14b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W. W. II | | 17. INFORMANT ADDRESS FAMILY RECORDS |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UNCAL HERNIATION DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL METASTASIS DUE TO, OR AS A CONSEQUENCE OF (c) RENAL CELL CARCINOMA | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 MINUTES 4 WEEKS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: ANGINA PECTORIS DUE TO CORONARY ARTERY DISEASE | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. n/a 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) n/a. | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN 19, 19 86, to JAN 20, 19 86, that (I) (we) lost saw the deceased alive on JAN 20, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did not view the body after death. | | | | |
| 22b. SIGNATURE T.A. TRALL | | DEGREE MD | | 22c. DATE SIGNED Jan 20 1986 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) T.A. TRALL | | 22e. ADDRESS JOHNS HOPKINS HOSPITAL BALTIMORE MD 21205 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE JAN. 24, 1986 | 23c. NAME OF CEMETERY OR CREMATORY HOLY SEPULCHRS CSM. | 23d. LOCATION CITY OR TOWN COUNTY STATE ROCHESTER New York | |
| 24. FUNERAL DIRECTOR NAME EVANS CHAPEL OF CHIMES | | 25a. DATE REC'D. BY REGISTRAR JAN 24 1986 | | 25b. REGISTRAR'S SIGNATURE Barbara R. Randle |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial permit. Then please remove column paper, page 3, and send it to the funeral home. The funeral home should be notified within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

025050



ROBBIE MORTON 6/002

UNO 2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 01283 | |
|--|--|--|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 050173 | | 1. DECEASED NAME (TYPE OR PRINT) WAI LAM | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 21 86 | | 2b. HOUR 10 16 A M | |
| 3. SEX MALE | | 4. RACE oriental | | 5. DATE OF BIRTH MONTH DAY YEAR 10 10 34 | | 6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CHINA | | 7b. CITIZEN OF WHAT COUNTRY? CHINA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV OF MARYLAND HOSP. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) COOK | | 12b. KIND OF BUSINESS OR INDUSTRY RESTAURANT | | | |
| 13a. STATE md. | | 13b. COUNTY USA | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 929 W Saratoga St. 21223 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST SUN LAM | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST TAI CHUNG | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 064-54-9139 | | 17. INFORMANT Glen Burnie, Maryland 21061 Lung Tai Ng 1055 Seventh Street | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIO PULMONARY arrest | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/21 , 19 86 , to 1/21 , 19 86 , that (I) (we) last saw the deceased alive on 1/21 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Edward B. Polgiano | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 1/21/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD B. POLGIANO | | | | 22e. ADDRESS UNIV OF Maryland Hospital | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/23/86 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A A Md | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Raymond C. Fink Glen Burnie, Md 21061 | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 22 1986 | | 25b. REGISTRAR'S SIGNATURE J. Davidson | | | |

BP

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

008174

#5 Pdm G.L.I.
11/10/86 Kam
FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

01284

| | | | | | | | |
|--|--|--|---|---|----------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Kenneth Lambert | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 4 86 | | 2b. HOUR 1 12 AM | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 7 30 13 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 67 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER | |
| 12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION | | | | | | | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN ARBUTUS | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET ADDRESS 1303 NORTH AVENUE | | 13f. CITY OR TOWN 21227 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL LEE LAMBERT | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DELLA MARGARET ASCUE | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WW2 | | 16b. SOCIAL SECURITY NO. 415-12-6542 | | 17. INFORMANT ADDRESS MRS. ELEANOR P. LAMBERT 1303 NORTH AVE | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Oat Cell Carcinoma of Ovary DUE TO, OR AS A CONSEQUENCE OF (c) Restrictive Pericardial Disease | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Congestive Heart Failure | | | | | | | |
| 19a. DATE OF OPERATION 12/30/85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Severe Pericardial Effusion | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/30 19 85 to 1/4 19 86 , that (I) (we) lost saw the deceased alive on 1/4/86 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Gayle P. Myers, M.D. | | | | DEGREE MD | | 22c. DATE SIGNED 1/4/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gayle P. Myers, M.D. | | | | 22e. ADDRESS 3001 S. Hanover St. Balto, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 01/07/86 | | 23c. NAME OF CEMETERY OR CREMATORY GLENWOOD CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE BRISTOL SULLIVAN TENNESSEE | |
| 24. FUNERAL DIRECTOR NAME ADDRESS AMBROSE FUNERAL HOME 1328 SULPHUR SPRING RD | | | | 25a. DATE REC'D. BY REGISTRAR JAN 6 1986 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, it must be accompanied by the medical certificate.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

151009

21



017132

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|--|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Helen Louise Landauer | | | 2a. DATE OF DEATH MONTH DAY YEAR 1-9-86 | | | 2b. HOUR 1000aM | | | |
| 3 SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR May 4, 1880 | | 6. AGE (IN YEARS LAST BIRTHDAY) 105 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 1000aM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital, Balto., Md. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Never Worked | | 12b. KIND OF BUSINESS OR INDUSTRY N/A | |
| 13a. STATE Maryland | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James Edward Landauer | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maryanne Longe | | | 13e. STREET ADDRESS / ZIP CODE 4501 Old Frederick Rd., 21229 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-46-3965 | | 17. INFORMANT ADDRESS Carol Baker 4501 Old Frederick Road Baltimore, MD. 21229 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Tachycardia DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) and Congestive Heart Failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5:00AM / 9 19 86 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 100M / 9 19 86 | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5:00AM / 9 19 86 to 10:00M / 9 19 86 , that (I) (we) last saw the deceased above , (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE A.L. Vance | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/9/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.L. VANCE | | | 22e. ADDRESS 900 CATON AVE BALTO., MD. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment | | | 23b. DATE 1/13/86 | | 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Mausoleum | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | |
| 24. FUNERAL DIRECTOR NAME Leton M. & Russell C. Witzke Funeral Homes P.A. | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 14 1986 | | 25b. REGISTRAR'S SIGNATURE | |
| 1630 Edmondson Avenue, Catonsville, MD. 21228 | | | | | | | | | |

notified at once.

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MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 1 DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| | | ANTON | | LEO LANG | | JANUARY 26, 1986 | | 08:30pm | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH MONTH DAY YEAR | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| Male | | White | | Aug. 8, 1929 | | 56 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | U.S.A. | | | | BALTIMORE CITY | | MD. | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| BALTIMORE | | THE JOHNS HOPKINS HOSPITAL | | Supervisor | | Soc. Sec. Adm. | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE | |
| Maryland | | Arundel | | Glen Burnie | | | | 7646 Hennesey Ct. 21061 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | |
| Anton | | Lang | | Veronica | | Czekalski | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT (Son) ADDRESS | | Same as | | # 13 | |
| Yes | | ?? | | 215/28/4363 | | Mr. Timothy D. Lang | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acquired Immuno deficiency Syndrome</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>2 years</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>liver failure</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 26</u> , 19 <u>86</u> , to <u>Jan 26</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>Jan 26</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE <u>David P. Carbone</u> MD PhD | | 22c. DATE SIGNED <u>1-26-86</u> | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | |
| DAVID P. CARBONE | | JOHNS HOPKINS HOSPITAL | | 600 N WOLFE ST BALTO, MD 21205 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Cremation | | January 28, 1986 | | Security Process | | Catonsville Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | 25. REGISTRATION SIGNATURE | | | | | |
| Singleton Funeral Home, Glen Burnie, Md. | | | | JAN 28 1986 | | | | | |

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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REPORT - MONTICLO & CO

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01287

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|---|---|---|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) MADELINE W. LANGLEY | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 16 86 | | 2b. HOUR 2:59 A M | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 12 28 13 | | 6. AGE (IN YEARS-LAST BIRTHDAY) 72 YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD | | | |
| 10. CITY OR TOWN OF DEATH Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5623 Pilgrim Road 21214 | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Md. | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 5623 Pilgrim Rd. 21214 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Stanley M. Ward | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen S. Stevenson | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-10-6998 | | 17. INFORMANT ADDRESS Mr. Joseph Langley Same as #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 8842 IMMEDIATE CAUSE (a) Chronic obstructive lung disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 yrs | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Fell out of bed on day of death, but pt. was end-stage COPD & very debilitated. | | | | | | | | | |
| 19a. DATE OF OPERATION None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 1 16 1986 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) Fell out of bed | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) HOME | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug 19 79 to Present 19____ that (I) (we) last saw the deceased alive on OCT 22 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Wilmot C Ball MD | | | | 22c. DATE SIGNED 1/24/86 | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILMOT C. BALL, JR | | |
| 22e. ADDRESS Good Samaritan Hospital Baltimore 21239 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b. DATE 1/16/86 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR NAME Anatomy Board | | | | ADDRESS Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR JAN 28 1986 | | 25b. REGISTRAR'S SIGNATURE John Davidson-Randall | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 2 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01288

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Joseph D. Lansinger | | | 2a. DATE OF DEATH MONTH DAY YEAR Jan. 23, 1986 | | 2b. HOUR 1:45 am | | | | |
| 3 SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 11 29 12 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 74 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance | | 12b. KIND OF BUSINESS OR INDUSTRY US Gov't. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | 13b. COUNTY Baltimore | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE 14 Mallow Hill Rd. 21229 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Thomas Lansinger | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth Agnew | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) WW 11 | | 17. INFORMANT ADDRESS Mary A. Lansinger 14 Mallow Hill Rd. Baltimore, Maryland 21229 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Emphysema PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Emphysema | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION 1-25-86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on 1-25-86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Baskaran | | | | DEGREE M.D. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1-24-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sambandam Baskaran, M.D. | | | | 22e. ADDRESS 3455 Wilkens Ave. Baltimore, 21229 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1 - 25 - 86 | | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Prk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Ho.Co. Md. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Gary L. Kaufman Funeral Home 5695 Main St. Elkridge, Maryland 21227 | | | | 25a. DATE REC'D. BY REGISTRAR JAN 24 1986 | | 25b. REGISTRAR'S SIGNATURE John Davidson-Randall | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The deceased must be removed to the funeral home within 72 hours after death.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner may be notified at once.

BP

021018

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|---|--------------------|---|-------------------|---|------------|--|------------|----------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST HAYWOOD | MIDDLE LAWRENCE | LAST LAWRENCE | 2a. DATE OF DEATH | | MONTH 1 | DAY 16 | YEAR 86 | 2b. HOUR 11:35 AM | |
| 3. SEX MALE | | 4. RACE Col | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PROVIDENT HOSPITAL BALTIMORE | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Roofers | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 1938 Ridgehill Ave 21217 | | | |
| 14. FATHER'S NAME Ernest Lawrence | | 15. MOTHER'S MAIDEN NAME Maggie Mayo | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. 243-84-2573 | | 17. INFORMANT Miss Barbara Mine 1938 Ridgehill Ave 21217 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis, Right lower lobe DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-10-86, to 1-16-86, that (I) (we) last saw the deceased alive on 1-16-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Sher A Hashmi | | DEGREE MD | | 22c. DATE SIGNED 1-16-86 | | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHER AP2AL HASHMI | | | |
| 22e. ADDRESS 2600 LIBERTY HEIGHTS AVE BALTIMORE 21215 | | 23a. BURIAL, CREMATION, REMOVAL (TYPE OF) | | 23b. DATE 1-20-86 | | 23c. NAME OF CEMETERY OR CREMATORY Church Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE North Carolina | | | |
| 24. FUNERAL DIRECTOR NAME Joseph L. Russ | | ADDRESS 2522 North Ave | | 25a. DATE REC'D. BY REGISTRAR JAN 17 1986 | | 25b. REGISTRAR'S SIGNATURE | | | | | |

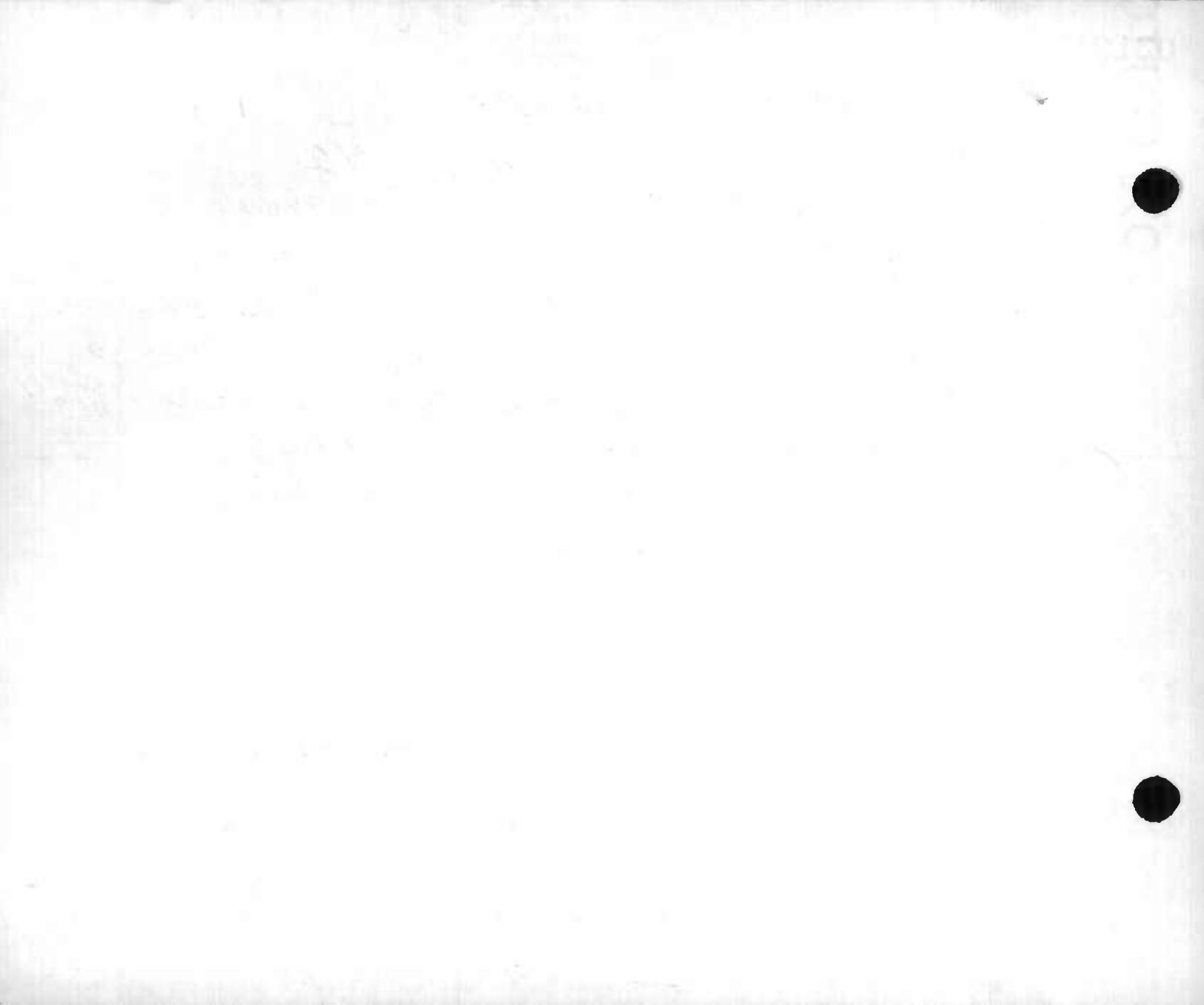
MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP



023127

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Ruby NMI Lawson | | | 2a. DATE OF DEATH MONTH 1 DAY 18 YEAR 86 | | 2b. HOUR 0445 M |
| 3. SEX F | 4. RACE B | 5. DATE OF BIRTH MONTH 9 DAY 9 YEAR 28 | | 6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS. | IF UNDER 1 YEAR MONTHS 0 DAYS 0 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Unw | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemploy | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | 13b. COUNTY Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 2450 W. Baltimore St. 21223 | | |
| 14. FATHER'S NAME FIRST Perry MIDDLE Hudson LAST Bell | | 15. MOTHER'S MAIDEN NAME FIRST Killie MIDDLE Bell LAST Bruce | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | 16b. SOCIAL SECURITY NO. 220-22-6802 | 17. INFORMANT ADDRESS Cheryl McKnight 5050 Carmine Ave | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF. (b) pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a End stage cardiomyopathy | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Barditch | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED 1/18/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARDITCH | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 1/22/86 | 23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Wet | 23d. LOCATION CITY OR TOWN Owings Mills COUNTY STATE Md | | |
| 24. FUNERAL DIRECTOR NAME William C. March F/H West ADDRESS 4300 Wabash Avenue | | 25a. DATE REC'D. BY REGISTRAR JAN 21 1986 REGISTRAR'S SIGNATURE | | | |

BP _____

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1- FOR
STATE
REGISTERSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

01291

| | | | | | |
|---|--|--|---|--|---|
| 1 DECEASED NAME (TYPE OR PRINT) RICHARD Theodore LEATHERMAN, Sr. | | | 20 DATE OF DEATH MONTH DAY YEAR 1-27-86 | | 2b HOUR 12:42 P |
| 1 SEX MALE | 4 RACE C 1 | 5 DATE OF BIRTH MONTH DAY YEAR 04 01 22 | | 6 AGE (IN YEARS LAST BIRTHDAY) 63 YRS | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | 7b CITIZEN OF WHAT COUNTRY? USA | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH CITY/BALTO. MD. | | |
| 10 CITY OR TOWN OF DEATH BALTO. | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) EMERGENCY MEDICAL SYSTEMS | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MACHINIST | | 12b KIND OF BUSINESS OR INDUSTRY ALUMINUM |
| 13a STATE MD | | 13b COUNTY WASHINGTON | 13c CITY OR TOWN SHARPSBURG | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e STREET ADDRESS / ZIP CODE 129 E. MAIN ST. 21782 |
| 14 FATHER'S NAME FIRST MIDDLE LAST LEO Rodney LEATHERMAN | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARTORIE Lee BENDER | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 217-16-2601 | | 17 INFORMANT ADDRESS RODNEY E. LEATHERMAN Sharpsburg, MD 21782 XXXXXXXXXX | |

| | | | | |
|---|---|---|--|--|
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4-5 day | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Resp. Failure (ARDS) | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a see above | | | | |
| 19a DATE OF OPERATION see above | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED see above | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 1 15 1986 | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) MVA | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) near home | 21f LOCATION STREET CITY OR TOWN COUNTY STATE Holter Rd., Middletown, Frederick Co., Md. | | |
| 22a I certify that (I) (this hospital) attended the deceased from 1-15-86 to 1-27-86 , that (I) (we) last saw the deceased alive on 19-86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death | | | | |
| 22b SIGNATURE [Signature] | DEGREE Attending Physician | | 22c DATE SIGNED 1/27/86 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) B. A. | | 22e ADDRESS M. I. E. M. S. S. 225. Green | | |

| | | | | |
|---|----------------------------------|---|--|--|
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b DATE Jan. 31, 1986 | 23c NAME OF CEMETERY OR CREMATORY Mt. View Cemetery | 23d LOCATION CITY OR TOWN COUNTY STATE Sharpsburg Washington Maryland | |
| 24 FUNERAL DIRECTOR NAME ADDRESS Major M. Osborne Williamsport, MD 21795 | | 25a DATE REC'D. BY REGISTRAR FEB 03 1986 | 25b REGISTRAR'S SIGNATURE [Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director. Page 3 should be retained by the funeral director. Page 4 should be retained by the funeral director. Page 5 should be retained by the funeral director. Page 6 should be retained by the funeral director. Page 7 should be retained by the funeral director. Page 8 should be retained by the funeral director. Page 9 should be retained by the funeral director. Page 10 should be retained by the funeral director. Page 11 should be retained by the funeral director. Page 12 should be retained by the funeral director. Page 13 should be retained by the funeral director. Page 14 should be retained by the funeral director. Page 15 should be retained by the funeral director. 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Page 73 should be retained by the funeral director. Page 74 should be retained by the funeral director. Page 75 should be retained by the funeral director. Page 76 should be retained by the funeral director. Page 77 should be retained by the funeral director. Page 78 should be retained by the funeral director. Page 79 should be retained by the funeral director. Page 80 should be retained by the funeral director. Page 81 should be retained by the funeral director. Page 82 should be retained by the funeral director. Page 83 should be retained by the funeral director. Page 84 should be retained by the funeral director. Page 85 should be retained by the funeral director. Page 86 should be retained by the funeral director. Page 87 should be retained by the funeral director. Page 88 should be retained by the funeral director. Page 89 should be retained by the funeral director. Page 90 should be retained by the funeral director. Page 91 should be retained by the funeral director. Page 92 should be retained by the funeral director. Page 93 should be retained by the funeral director. Page 94 should be retained by the funeral director. Page 95 should be retained by the funeral director. Page 96 should be retained by the funeral director. Page 97 should be retained by the funeral director. Page 98 should be retained by the funeral director. Page 99 should be retained by the funeral director. Page 100 should be retained by the funeral director.

RECEIVED



CHINA

NO. 100

(1900)

1900

RECEIVED

1900

FEB 03 1900

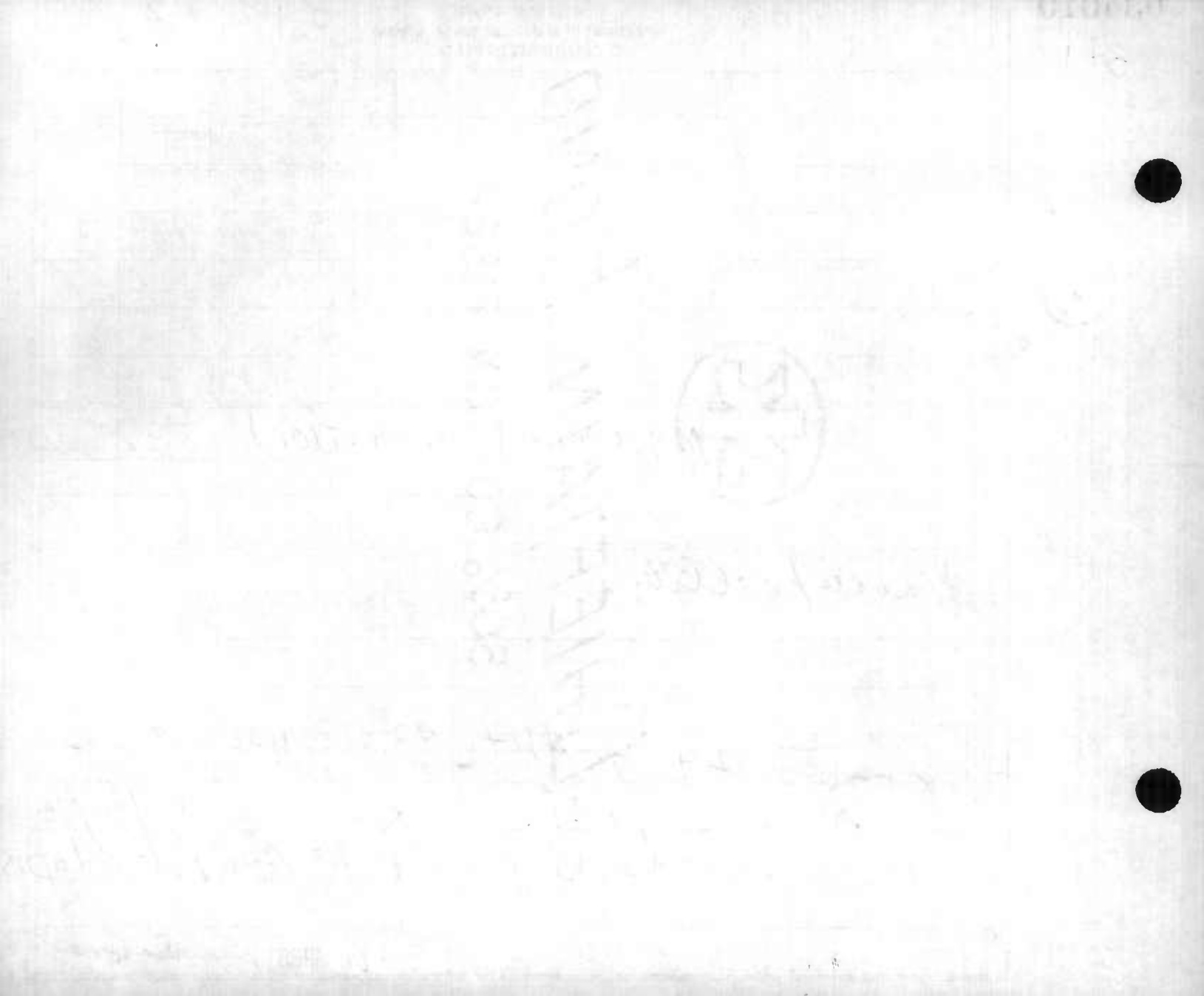
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|---|---|------------------------------------|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | |
| FIRST MIDDLE LAST | | | | | MONTH DAY YEAR | | | | |
| CLARENCE LEE | | | | | 1 26 86 | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7b. HOUR | |
| Male | | Black | | MONTH DAY YEAR 7 28 27 | | 58 YRS. | | M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| N.C. | | USA | | | | Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Balto. | | 3428 W. Caton Avenue | | | | Self-Employ. | | Shoe Repair | |
| 13a. STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | |
| Md. | | | | | Balto. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | |
| FIRST MIDDLE LAST | | | | | FIRST MIDDLE LAST | | | | |
| James O. Lee | | | | | Emma Williams | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | |
| Yes | | | 244-20-3943 | | Geraldine Lee 3428 W. Caton Avenue | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY: | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| (b) | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 18 | | | | | | | | | |
| Diabetes mellitus | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| | | | P.M. 19 | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION | | | |
| WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 2/14/86 to 1/26/86, that (I) last saw the deceased alive on 1/24/86, and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | 22c. DATE SIGNED | |
| Dr. Sunshine, M.D. | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 1/23/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | |
| DR. SUNSHINE, M.D. | | | | | | 6210 PK. Hts Ave, Balt, Md 21215 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | |
| Burial | | | 1/31/86 | | Garrison Forest Vet. | | OWINGS MILLS, Md. STATE | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| NAME ADDRESS | | | | | | JAN 30 1986 | | [Signature] | |
| Wm C March F.H. West 4300 Wabash Ave. | | | | | | | | | |



009175

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

01293

| | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) MARIE | | FIRST C. | | MIDDLE LEECH | | LAST | | 2a. DATE OF DEATH MONTH 01 DAY 04 YEAR 86 | | 2b. HOUR 00⁴⁰ AM | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH 07 DAY 14 YEAR 91 | | 6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NOrth Charles Gen. Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY - | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13b. STREET ADDRESS / ZIP CODE 2927 Berwick Ave. 21234 | | | |
| 13a. STATE Md. | | 13b. COUNTY - | | 13c. CITY OR TOWN Balto. | | 15. MOTHER'S MAIDEN NAME FIRST Frances MIDDLE Salvo LAST Salvo | | | | | |
| 14. FATHER'S NAME FIRST Vincent MIDDLE Cefalu LAST Cefalu | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO 213-74-5402 | | 17. INFORMANT ADDRESS Alex V. Leech 2927 Berwick Ave. 21234 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTICEMIA DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) - DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a POSSIBLE ENDOCARDITIS, ANAEMIA | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) - | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET - CITY OR TOWN - COUNTY - STATE - | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-31-1985 to 1-4-1986 , that (I) (we) last saw the deceased alive on 1-4-1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Sudhir D. Patel | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1-4-86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SUDHIR D. PATEL | | | | | | 22e. ADDRESS NORTH CHARLES GEN. HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-7-86 | | 23c. NAME OF CEMETERY OR CREMATORY MOREland Cem. | | 23d. LOCATION CITY OR TOWN Balto. COUNTY Balto. STATE md. | | | | | |
| 24. FUNERAL DIRECTOR NAME John C. Miller Inc. 6415 Belair Rd. 21206 ADDRESS - | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 7 1986 | | 25b. REGISTRAR'S SIGNATURE John C. Miller | | | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

003172

11.11.11



010020

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove the above paper (pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal).

IMPORTANT: If page 1 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be called to make an autopsy.

| STATE OF MARYLAND 8 6 0 1 2 9 4 | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|---|--|---|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Charles Sebastian Leimbach</i> | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>1/6/86</i> | | | | 2b. HOUR <i>825^{PM}</i> | | | | | | | |
| 3. SEX <i>Male</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>9 11 94</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>91</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (WHEN NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Francis Scott Key Medical Center</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Manager</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Fairlanes, Inc.</i> | | | | | | | |
| 13a. STATE <i>Maryland</i> | | | | 13b. COUNTY <i>Baltimore</i> | | 13c. CITY OR TOWN <i>Timonium</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE <i>104 Belfast Rd. 21093</i> | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Charles Leimbach</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Foltz</i> | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> IF YES, GIVE WAR OR DATES <i>No</i> | | | | 16b. SOCIAL SECURITY NO. <i>219-22-9066</i> | | 17. INFORMANT ADDRESS <i>Bonnie V. Leimbach - Same as #13e</i> | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Aspiration of vomitus</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>diabetes, GI Bleed, SIPCVA, Renal failure</i> | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (this hospital) attended the deceased from <i>12/27/85</i> , 19____, to <i>1/6/86</i> , 19____, that (we) lost saw the deceased alive on <i>1/6/86</i> , 19____, and that in (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>Theodore MacKinnon</i> | | | | DEGREE <i>MD</i> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED <i>1/6/86</i> | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Theodore MacKinnon</i> | | | | 22e. ADDRESS <i>RSKMC</i> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Entombment</i> | | | | 23b. DATE <i>1-10-86</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Lorraine Mausoleum</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Woodlawn Balto. Md.</i> | | | | | | | |
| 24. FUNERAL DIRECTOR NAME <i>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</i> | | | | ADDRESS <i>1050 York Rd.</i> | | 25a. DATE REC'D. BY REGISTRAR <i>JAN 8 1986</i> | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | | | |

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

017027

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

MEDICAL CERTIFICATION

| | | | | | |
|---|--|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST <u>ADA</u> MIDDLE <u>SYSTERA</u> LAST <u>LEIZEAR</u> | | 2a. DATE OF DEATH MONTH <u>11</u> DAY <u>10</u> YEAR <u>86</u> | | 2b. HOUR <u>4:35</u> P.M. | |
| 3. SEX <u>F</u> | 4. RACE <u>W</u> | 5. DATE OF BIRTH MONTH <u>8</u> DAY <u>08</u> YEAR <u>04</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>81</u> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>WEST VIRGINIA</u> | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Balt city</u> MD. | |
| 10. CITY OR TOWN OF DEATH <u>Balt city</u> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Seton Hill Manor</u> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Medical Secretary</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u> |
| 13a. STATE <u>MARYLAND</u> | | 13b. COUNTY | 13c. CITY OR TOWN <u>Baltimore</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST <u>FRANZ</u> MIDDLE <u>WINTER</u> LAST | | 15. MOTHER'S MAIDEN NAME FIRST <u>HELIA</u> MIDDLE <u>COMISTOCK</u> LAST | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u> | | 16b. SOCIAL SECURITY NO. <u>217052753</u> | | 17. INFORMANT ADDRESS <u>W. King Rd 501 West Franklin St</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio-respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Alzheimer's Disease</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30min.</u> <u>30min.</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| 22a. certify that (I) (this hospital) attended the deceased from <u>9-14</u> , 19 <u>84</u> , to <u>1-10</u> , 19 <u>86</u> that (I) (we) last saw the deceased alive on <u>1-10</u> , 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | |
| 22b. SIGNATURE <u>Jaime Punzalan</u> | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>1/11/86</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JAIME PUNZALAN</u> | | 22e. ADDRESS <u>5214 Hayford Rd. Balto. Md. 21241</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>CREMATION</u> | | 23b. DATE <u>11/13/86</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>GREENMOUNT</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>BALTIMORE CITY MARYLAND</u> |
| 24. FUNERAL DIRECTOR NAME <u>MITCHELL-WIEDEFELD HOME, INC.</u> | | ADDRESS <u>13410 MD. 21212</u> | | 25a. DATE RECEIVED BY REGISTRY <u>JAN 14 1986</u> | |

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070010



COLLECTOR

RECEIVED

009131

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) JOHN GEORGE LESHO | | | 2a. DATE OF DEATH MONTH DAY YEAR January 2, 1986 | | 2b. HOUR M |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR October 16, 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, City | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 103 East Lake Avenue 21212 | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner/Contractor | 12b. KIND OF BUSINESS OR INDUSTRY Heat/Air Cond. | |

| | | | | | | |
|---|--|--|---|--|---|---|
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | 13b. COUNTY -- | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 103 East Lake Ave. 21212 |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Charles Lesho | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Bodnar | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 286-05-4005 | | 17. INFORMANT ADDRESS Patti A. Lesho 103 East Lake Ave. 21212 | | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) glaucoma, strain | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

| | | | | | |
|--|--|--|--|--|---|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/10/85 , 19____, to 12/5/85 , 19____, that (I) (we) lost saw the deceased alive on 12/5/85 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE John Mann | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/2/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Mann | | 22e. ADDRESS 611 Park Avenue | | | |

| | | | |
|---|----------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE Jan. 6, 1986 | 23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley | 23d. LOCATION CITY OR TOWN COUNTY STATE Lutherville Baltimore Maryland |
| 24. FUNERAL DIRECTOR NAME ADDRESS Mitchell-Wiedefeld Home 6500 York Road 21212 | | 25a. DATE REC'D. BY REGISTRAR JAN 7 1986 | 25b. REGISTRAR'S SIGNATURE John Mann |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

January 2, 1986

John Doe

08

October 15, 1985

which

also

Washington, D.C.

and

for the

United States Department of Justice

1000 15th Avenue S.W.

Atlanta, Georgia

1000 15th Avenue S.W.

Atlanta, Georgia

Atlanta, Georgia

Robert

John

John

John

John

1000 15th Avenue S.W. Atlanta, Georgia 30334

Enclosure



1000 15th Avenue S.W.

Atlanta, Georgia

John Doe, 1000 15th Avenue S.W.

Atlanta, Georgia

1000 15th Avenue S.W. Atlanta, Georgia 30334

008157

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

01297

| | | | | | | | | |
|--|--------|---|-------------------------|--|---|---|---|---|
| 1 DECEASED NAME (TYPE OR PRINT) | | | 2a DATE OF DEATH | | | 2b HOUR | | |
| FIRST | MIDDLE | LAST | MONTH | DAY | YEAR | | | |
| Katherine A. Letmate | | | 1 | 2 | 86 | 6PM | | M |
| 3 SEX | | 4 RACE | 5 DATE OF BIRTH | | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR |
| FEMALE | | WHITE | MONTH | DAY | YEAR | 58 | | MONTHS |
| | | | 9 | 22 | 27 | | | DAYS |
| | | | | | | | | HOURS |
| | | | | | | | | MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | |
| | | USA | | | | Baltimore City MD. | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY |
| Balto. City | | St. Agnes Hospital | | | | Retired | | |
| 13a STATE | | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | |
| Md. | | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME | | | 15 MOTHER'S MAIDEN NAME | | 13e STREET ADDRESS / ZIP CODE | | | |
| FIRST MIDDLE LAST | | | FIRST MIDDLE LAST | | 21230 | | | |
| Anthony Lamp | | | Grace Butler | | 2919 Georgetown Rd. | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT ADDRESS | | | |
| No | | | 215-228-1466 | | Elwood Letmate 2919 Georgetown Rd. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF - (b) <u>metastatic carcinoma (tongue & lung)</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1 yr</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| 12/11/85 | | Ca base of tongue | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| | | P.M. 19 | | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| | | | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>10/31</u> , 19 <u>85</u> , to <u>12/19</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>12/19</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b SIGNATURE | | | | | | DEGREE | | 22c DATE SIGNED |
| <u>William C. Gray</u> | | | | | | ATTENDING PHYSICIAN | | 1/3/86 |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e ADDRESS | | |
| W GRAY | | | | | | Univ of Md Hosp. | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION CITY OR TOWN COUNTY STATE | | |
| Burial | | 1-6-86 | | Meadowridge Mem. Pk. | | Elkridge Howard Maryland | | |
| 24 FUNERAL DIRECTOR | | | | 25a DATE REC'D. BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | |
| Hubbard Funeral Home, Inc., 4107 Wilkens Ave. | | | | JAN 6 1986 | | <u>Jane Davidson-Randall</u> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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013015

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|---|--|---|--|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDNA G. LETTS | | | 2a. DATE OF DEATH MONTH DAY YEAR 1-7-86 | | 2b. HOUR 9:40 AM | | | |
| 3. SEX FEMALE | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 7-13-1893 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 92 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE City MD. | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Avon Sales | | 12b. KIND OF BUSINESS OR INDUSTRY Retired | |
| 13a. STATE MD. | | 13b. COUNTY Balto. | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE 5712 Leith Walk - 21239 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles M. Geyer | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Elizabeth Schmidt | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 310-12-43493 | | 17. INFORMANT ADDRESS Mrs. June Hardesty - 6005 Glen Falls Ave. 21206 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-11-1985 to 1-7-1986 , that (I) (we) last saw the deceased alive on 1-7-1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE Lokeswararao Edara | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1-7-86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) LOKESWARARAO. EDARA | | | | 22e. ADDRESS MD. C/O Good Samaritan Hospital - 21236 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-10-85 | | 23c. NAME OF CEMETERY OR CREMATORY I.O.O.F. Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Pennsville, Indiana | | |
| 24. FUNERAL DIRECTOR NAME John C. Miller Inc-6415 Belair Rd. - 21206 | | | | 25a. DATE REC'D. BY REGISTRAR JAN 9 1986 | | 25b. REGISTRAR'S SIGNATURE Davidson-Randall | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01299

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) RUTH MAY LEVIN | | 2a. DATE OF DEATH 1-19-86 YEAR 19-86 | | 2b. HOUR 2³⁰ a.m. | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 9-18-1919 | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS. | | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MACHINE OPERATOR | |
| 12b. KIND OF BUSINESS OR INDUSTRY BROMO-SELTZER CO. | | 13a. STREET ADDRESS / ZIP CODE 4014 ELMORA AVE. 21213 | | | |
| 13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN | | | |
| 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MABEL UNKNOWN | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | | |
| 16b. SOCIAL SECURITY NO. 212-16-8534 | | 17. INFORMANT ADDRESS LOUIS LEVIN (HUSBAND) SAME ADDRESS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac/Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Dehydration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Rectal cancer | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/27 , 19 85 , to 1/19 , 19 86 , that (I) (we) last saw the deceased alive on 1/18 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE G. Abesada-Terk | | DEGREE | | 22c. DATE SIGNED 1/19/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Guillermo Abesada-Terk | | 22e. ADDRESS 4 Montaigne Court #315 | | 22f. DATE OF DEATH 1-19-86 | |
| 23a. BURIAL, CREMATION, REMOVAL (IF CREM.) BURIAL | | 23b. DATE 1/22/86 | | 23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK | |
| 23d. LOCATION CITY OR TOWN BALTIMORE | | 23e. COUNTY MD. | | 23f. STATE MD. | |
| 24. FUNERAL DIRECTOR SCHIMONEK FUNERAL HOME, INC. | | 24b. ADDRESS 3331 Brehms Lane, Balto. Md. 21213 | | 25a. DATE OF REGISTRATION JAN 20 1986 | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the completed page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|--|---|---|---|-----------------------|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) ELIZABETH A. LEWIS | | | 2a. DATE OF DEATH MONTH DAY YEAR January 25, 1986 | | 2b. HOUR 7:30 P.M. | | | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR July 27, 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | IF UNDER 74 HRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4536 Schenley Road | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesperson | | 12b. KIND OF BUSINESS OR INDUSTRY Clothing | | | |
| 13a. STATE MD | | 13b. COUNTY | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 4536 Schenley Road, 21210 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST David Arthur | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Duffy | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 214 14 9226 | | 17. INFORMANT Ellin C. Lewis, | | | | ADDRESS Same | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) metastatic Breast Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: c Chronic obstructive Pulmonary Disease | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from January 12, 1986, to January 16, 1986, that (I) (we) last saw the deceased alive on January 16, 1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Gary Manko | | | | DEGREE MD | | | | 22c. DATE SIGNED 1-27-86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Gary Manko, MD | | | | 22e. ADDRESS 11 E. Chestnut Hill Lane, MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/29/86 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto., MD | | | | | |
| 24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212 | | | | | | 25a. DATE REC'D BY REGISTRAR JAN 27 1986 | | 25b. REGISTRAR'S SIGNATURE John A. Williams | | | |

MEDICAL CERTIFICATION

29

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

January 25, 1975

Mr. J. Edgar Hoover

U.S. Department of Justice

Washington, D.C. 20535

Dear Mr. Hoover:

I am writing to you regarding the

matter of the

investigation of the

activities of the

organization known as

the "Black Panther Party"

and its various branches

throughout the United States.

I have been informed that

your office is currently

conducting an investigation

into the activities of this

organization and its

branches in the

024077

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) IRENE | | FIRST Robinson | | MIDDLE Lewis | | LAST | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 20, 1986 | | 2b. HOUR 8:21 M | |
| 3. SEX FEMALE | | 4. RACE Negro | | 5. DATE OF BIRTH MONTH DAY YEAR 7-16-22 | | 6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) M.D. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Labor | | 12b. KIND OF BUSINESS OR INDUSTRY - | |
| 13a. STATE M.D. | | 13b. COUNTY - | | 13c. CITY OR TOWN BALTO. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 429 N. Madeira ST #2123/ | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Johnny Lewis | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myrtle Green | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 214-18-5123 | | 17. INFORMANT ADDRESS Helen Brown 2711 Hugo Ave #2128 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metabolic acidosis DUE TO, OR AS A CONSEQUENCE OF (b) Vascular Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) Scurvy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 minutes 1 month | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Elevated Arterial Hypotension | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/1 , 19 86 , to 1/20 , 19 86 , that (I) (we) lost saw the deceased alive on 1/20 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Fred H. Williams | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 1/20/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Fred H. Williams | | | | 22e. ADDRESS The Johns Hopkins Hospital | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-25-86 | | 23c. NAME OF CEMETERY OR CREMATORY MT. Auburn Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. M.D. | | | | | |
| 24. FUNERAL DIRECTOR NAME BETTS FUNERAL Home | | | | ADDRESS 1129 N. Caroline ST | | 25a. DATE REG'D. BY REGISTRAR JAN 22 1986 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson | | | |

MEDICAL CERTIFICATION

921

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove the portion of the certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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CHIEF MANAGER

REBMA MOTION & CO

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Handwritten text at the bottom of the page, possibly a signature or date.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

029133

1- FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Sarah Lewis</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>1/15/1986</i> | | | 2b. HOUR <i>2 PM</i> | |
| 3. SEX <i>Female</i> | | 4. RACE <i>Black</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>9/19/1921</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>64</i> YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>S. Carolina</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Balto. City</i> MD. | |
| 10. CITY OR TOWN OF DEATH <i>Balto.</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Mercy Hosp.</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Computer Op.</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Fed. Gov't</i> | |
| 13a. STATE <i>Md.</i> | | | | 13b. COUNTY <i>Balto.</i> | | 13c. CITY OR TOWN <i>Balto.</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Ernest Hardy</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Eugenia</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>220-30-5271</i> | | 17. INFORMANT ADDRESS <i>Mr. Archie Lewis Same as #13</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Failure Disease</i> <i>Chronic obstructive Pulmonary</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Smoking</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>> 10 years</i> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Cor Pulmonale, hypochloremia</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? <i>Donation to Science</i> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) this hospital attended the deceased from <i>July 9</i> , 19 <i>89</i> to <i>1/15</i> , 19 <i>86</i> , that (1) (we) lost saw the deceased alive on <i>1/15</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>G. Henry MD</i> | | DEGREE <i>AL. ALEXANDER</i> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <i>1/15/86</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J. Kinney</i> | | 22e. ADDRESS <i>MERCY HOSP 301 St Paul St Baltimore MD.</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i> | | 23b. DATE <i>1/15/86</i> | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME ADDRESS <i>Anatomy Board Balto., Md.</i> | | | | | | | |

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30% COLLOID

MADE IN U.S.A.

016023

FOR ITEM Number 13e, 13b, Ph. Call
 1- STATE REGISTRAR
 1-16-86 B.W.
 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOSEPH LINEBERGER | | | 2a. DATE OF DEATH MONTH DAY YEAR 01 03 86 | | | 2b. HOUR 8:05A M | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 11 14 30 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 55 YRS | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD. | |
| 10. CITY OR TOWN OF DEATH city | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS / ZIP CODE 3402 MenLoDr. 21215 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche Smith | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN | | | | 16b. SOCIAL SECURITY NO. 317-24-6442 | | 17. INFORMANT ADDRESS Theodore Laster 4538 Northwood | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) TERMINAL CANCER SECONDARY TO CANCER OF STOMACH DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE 12/20 85 1/3 86 | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/3 19 86 , saw the deceased alive on 1/3 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death. | | | | | | | |
| 22a. SIGNATURE Kuang-Yen Huang | | | | DEGREE M.D. | | 22c. DATE SIGNED 1/3/86 | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) KUANG-YEN HUANG | | | | 22e. ADDRESS Bon Secours Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 1-7-86 | | 23c. NAME OF CEMETERY OR CREMATORY Westview Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | |
| 24. FUNERAL DIRECTOR NAME William C. Brown | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 13 1986 | | | |
| ADDRESS 1206-08 W. North ave | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and approved by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the death must be reported to the coroner.

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WILKINSON

WILKINSON



FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|-------------------|--|--------------------------------|--|------------------|---|----------|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR |
| David | | M | MORTON | Lipnick | 1 | 20 | 88 | 600P.M. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | | IF UNDER 74 HRS. | | |
| Male | White | 6 6 17 | | 68 | MONTHS | | DAYS | | |
| 7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Baltimore, Md. | USA | | | Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | University of Maryland Hospital | | | Chemical Engineer | | U.S. GOVT. | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE | | | | |
| Maryland | | BALTIMORE | Baltimore | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 3317 Ripple Road | | 21207 | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| Kain | | Lipnick | | Fannie Margolis | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | |
| NO | | 213-16-3481A | | MRS. JUDITH LIPNICK | | | | | |
| | | | | 3317 RIPPLE RD. BALTO., MD | | 21207 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septic Shock</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diffuse Lymphoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1 year</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>January 20, 1986</u> to <u>January 20, 1986</u> , that (I) (we) last saw the deceased alive on <u>January 20, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE <u>Russell R. DeLuca</u> | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>1/20/86</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | |
| Russell R. DeLuca | | 22. S. Greene St. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE JAN. 22, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY BETH EL MEM. PARK | | 23d. LOCATION RANDALETSTOWN | | COUNTY BALTO. STATE MD | |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | 25a. DATE REC'D. BY REGISTRAR JAN 24 1986 | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |

MEDICAL CERTIFICATION

028043

TO HOSPITAL OF MARYLAND: This form requires the physician to be present at the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed, the physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. This form is to be retained by the funeral director and should be retained with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "Removal," item 21 shows any other cause of death, if the deceased was not killed by the cause of death.

BP

017023

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARTHA LIPSCOMB | | | 2a. DATE OF DEATH MONTH DAY YEAR 01 09 86 | | | 2b. HOUR 1:37 P.M. | | | |
| 3. SEX F | | 4. RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR 04 05 06 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | | 13b. COUNTY BALTO | | 13c. CITY OR TOWN BALTO | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 1017 Bennett Place 21223 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James Jennings | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY Motley | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. 214-18-0938 | | 17. INFORMANT ADDRESS VENNON LIPSCOMB 418 LYNHURST AVE. | | | | | |

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|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF (b) UNKNOWN | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | |

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) HYPERTENSION | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Allen Solomon MD | | | | DEGREE MD | | 22c. DATE SIGNED 1/9/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Allen Solomon | | | | 22e. ADDRESS 22 S. Greene St B&H MD 21201 | | | |

| | | | | | | | |
|---|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 1-14-86 | | 23c. NAME OF CEMETERY OR CREMATORY Mount Auburn | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD | |
| 24. FUNERAL DIRECTOR NAME ADDRESS WM. C. MARCH F/H INC. 1101 E. North Ave. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 14 1986 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

015033

STAIR NOTICE 503

AND

SALE

X

NOT BOUND PLACE 503

015033

015033

010124

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Roberta Lipscomb | | 2a. DATE OF DEATH MONTH DAY YEAR 1/1/86 | | 2b. HOUR M | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 2/2/00 | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2003 N. Wolf St. (Home) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md. | | 13b. COUNTY Balto. | |
| 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 2003 N. Wolf St. 21213 | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) John Perkins | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Julia Perkins | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | |
| 16b. SOCIAL SECURITY NO. 212-01-9691 | | 17. INFORMANT ADDRESS Cleveland Hardy 3606 Reisterstown Rd | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE James A. Priest, M.D. | | DEGREE M.D. | | 22c. DATE SIGNED 1-2-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES A. PRIEST, M.D. | | 22e. ADDRESS 3101 Guyans Falls Hwy. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/6/86 | | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Park | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus Md. | | 25a. DATE REC'D. BY REGISTRAR JAN 8 1986 | | | |
| 24. FUNERAL DIRECTOR NAME Chas. A. Rice ESPA | | ADDRESS 1300 Eutaw Pl. | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

REBEL MOTION PICTURES

REBEL MOTION PICTURES



035070

1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

01307

| | | | | |
|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST <i>Margaret</i> MIDDLE <i>Loretta</i> LAST <i>List</i> <i>Margaret Loretta List</i> | | 2a. DATE OF DEATH MONTH DAY YEAR 01 28 86 | | 2b. HOUR 9:15 PM |
| 3. SEX FEMALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR 01 05 02 | | 6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD. |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FSK Med Center | | 12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Retired | 12b. KIND OF BUSINESS OR INDUSTRY Housework |
| 13a. STATE Md | | | | |
| 13b. COUNTY Baltimore | | | | |
| 13c. CITY OR TOWN Baltimore | | | | |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 13e. STREET ADDRESS / ZIP CODE 3910 Foster Ave 21224 | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Fahrmah | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Zahner 21224 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None | | 17. INFORMANT ADDRESS Loretta List 3910 Foster Ave. 21224 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Urosepsis</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____ | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-27</u> , 19 <u>86</u> , to <u>1-28</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE <i>[Signature]</i> | | DEGREE MD | | 22c. DATE SIGNED 1-28-86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) HTuch | | 22e. ADDRESS FSK Med Center | | 22f. EASTERN AVE |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-30-86 | | 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Eastwood, Balto. Co., Md. | | 24. FUNERAL DIRECTOR NAME Charles S. Zeiler & Son Inc. ADDRESS 901 S. Conkling St. | | |
| 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE IAN 31 1986 | | |

MEDICAL CERTIFICATION

29

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

01308

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST Stephen | | | MIDDLE Joseph | | | LAST Little | | | 2a. DATE OF DEATH KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> <input type="checkbox"/> | | | MONTH 1/ | | | DAY 2/ | | | YEAR 19 86 | | | 2b. HOUR M P | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX M | | | 4. RACE White | | | 5. DATE OF BIRTH MONTH 5 | | | DAY 10 | | | YEAR 63 | | | 6. AGE (IN YEARS) (LAST BIRTHDAY) 22 YRS. | | | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | | | 7c. DATE PRONOUNCED DEAD MONTH 1/ | | | DAY 2/ | | | YEAR 19 86 | | | 7d. HOUR P | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware | | | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital Shock Trauma | | | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY Manufacturing | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. STATE MD | | | | | | 13b. COUNTY Wicomico/Mardela Springs | | | | | | 13c. CITY OR TOWN YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | 13e. STREET ADDRESS MD Rt. 313/21837 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST Joseph | | | | | | | | | | | | MIDDLE Wayne | | | | | | | | | | | | LAST Little | | | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST Nancy | | | | | | | | | | | | MIDDLE Wright | | | | | | | | | | | | LAST Wright | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | | | | | | | | | (IF YES, GIVE WAR OR DATES) - | | | | | | | | | | | | 16b. SOCIAL SECURITY NO. 216-80-0520 | | | | | | | | | | | | 17. INFORMANT ADDRESS Rt. 1, Box 198 Joseph W. Little Mardela Springs, MD | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | | | 21b. TIME OF INJURY HOUR XX MONTH DAY YEAR 9:55 P.M. 12/28/19 85 | | | | | | | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver of auto, lost control/fixed object | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway | | | | | | | | | | | | 21f. LOCATION STREET Delmar Road & Rt. 313, Salisbury, Wicomico, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | | | | | | | | | TITLE (SPECIFY) M.D. Assistant | | | | | | | | | | | | DATE SIGNED 1/3/86 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. | | | | | | | | | | | | ADDRESS 111 Penn St. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | | | | | | | | | 23b. DATE 1-4-86 | | | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY Riverton Cemetery | | | | | | | | | | | | 23d. LOCATION CITY OR TOWN Riverton Wicomico Maryland | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Zeller Funeral Home, Sharptown, MD | | | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 16 1986 | | | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 801 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 801 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

01309

| | | | | | | | | | | |
|--|--|--|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) MARIE CATHERINE LITZ | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 14 1986 | | | 2b. HOUR 7:01 PM | | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR AUG. 18, 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 2 YRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY - | | |
| 13a. STATE MD. | | | 13b. COUNTY - | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 3118 BRENDAN AVE. 21213 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST HARRY L. THOMPSON | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH BILZ | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 215-10-8848B | | 17. INFORMANT DONALD LITZ (HUSBAND) SAME ADDRESS | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ventricular F. Cillation</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>thb</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>3 years</u> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Chronic congestive heart failure</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from <u>11-7</u> , 19 <u>80</u> , to <u>11-14</u> , 19 <u>86</u> , that (2) we last saw the deceased alive on <u>1-10</u> , 19 <u>84</u> , and that in (3) our opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>George Lowe</u> | | | DEGREE MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1-15-86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. GEORGE LOWE | | | 22e. ADDRESS 3703 BELAIR RD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 1/17/86 | | 23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD. | | | |
| 24. FUNERAL DIRECTOR SCHIMUNEK FUNERAL HOME, INC. 3331 Brehms Lane, Balto. Md. 21213 | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 20 1986 | | 25b. REGISTRAR'S SIGNATURE <u>W. A. Anderson</u> | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove completed Page 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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1 - FOR
STATE
REGISTRAR

CUO TUNG LIU

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|---|---|----------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) <i>CUO TUNG LIU</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>1 24 86</i> | | 2b. HOUR <i>3:50 PM</i> |
| 3. SEX <i>M</i> | 4. RACE <i>Oriental</i> | 5. DATE OF BIRTH MONTH DAY YEAR <i>2 25 33</i> | 6. AGE (IN YEARS LAST BIRTHDAY) <i>52</i> YRS | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Taiwan</i> | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD | | |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>University of Maryland Cancer Center</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Biochemist</i> | 12b. KIND OF BUSINESS OR INDUSTRY <i>Research</i> | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE HOMELESS) 43a. STATE <i>Virginia</i> | 13b. COUNTY <i>Fairfax</i> | 13c. CITY OR TOWN <i>Great Falls</i> | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE <i>Vernon Drive 22066</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Chin-Tai Lin</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Chin-Chin Chan</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 16b. SOCIAL SECURITY NO. <i>329-38-9787</i> | 17. INFORMANT ADDRESS <i>Dr. Thomas T. Walsh, Univ. MD Cancer Center</i> | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) *Intracerebral Hemorrhage*

DUE TO, OR AS A CONSEQUENCE OF

(b) *Hemorrhagic Stroke*

DUE TO, OR AS A CONSEQUENCE OF

(c) *Thrombocytopenia*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a

Acute Non-Lymphocytic Leukemia

| | | | |
|--|---|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Acute Non-Lymphocytic Leukemia</i> | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1/27/86</i> to <i>1/29/86</i> , that (I) (we) last saw the deceased alive on <i>1/23/86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 27b. SIGNATURE <i>Thomas T. Walsh</i> | DEGREE <i>MD</i> | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 27c. DATE SIGNED <i>1/24/86</i> |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. Thomas T. Walsh</i> | | 27e. ADDRESS <i>Univ. MD Cancer Center</i> | |

| | | | |
|---|--------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i> | 23b. DATE <i>Feb. 2, 86</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>Metropolitan Crematory</i> | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Alexandria, Va.</i> |
| 24. FUNERAL DIRECTOR NAME <i>Money & King Vienna Fun'l Hm</i> | | 25a. DATE REC'D. BY REGISTRAR <i>FEB 03 1986</i> | |
| ADDRESS <i>Vienna, Va.</i> | | 25b. REGISTRAR'S SIGNATURE <i>Julia Davidson</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificates Pages 1 and 2 should be kept and within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

UNITED STATES
NAVY



014022

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

20. DATE OF DEATH MONTH DAY YEAR 1 2 86 1201 M

1. DECEASED NAME FIRST MIDDLE LAST
Theresa R. Loar

3. SEX F

4. RACE W

5. DATE OF BIRTH MONTH DAY YEAR
04-08-1958

6. AGE (IN YEARS LAST BIRTHDAY) 27 YRS

IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH City MD.

10. CITY OR TOWN OF DEATH Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Francis Scott Key Medical Center

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife

12b. KIND OF BUSINESS OR INDUSTRY own home

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD

13b. COUNTY Baltimore

13c. CITY OR TOWN Baltimore

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS 7307 Shipway/21222

14. FATHER'S NAME FIRST MIDDLE LAST
Carl Miller

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Martha Walker

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO

16b. SOCIAL SECURITY NO. 220-72-4569

17. INFORMANT ADDRESS
Mr. Wayne L. Loar, Baltimore, MD - husband

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
7 912
DUE TO, OR AS A CONSEQUENCE OF
(b) Hypoxia 2nd resp arrest - brain death 15 min
DUE TO, OR AS A CONSEQUENCE OF
(c) Aspiration at home 3 d PTA 3 of

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
Multiple sclerosis

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☒ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/31 19 85 to 1/2 19 86, that (I) (we) last saw the deceased alive on 11/2/85 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE B. Massey

DEGREE MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED 1/2/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. A. Massey

22e. ADDRESS FSC hospital

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

23b. DATE 01-06-1986

23c. NAME OF CEMETERY OR CREMATORY Restlawn Memorial Pk.

23d. LOCATION CITY OR TOWN COUNTY STATE
Cumberland Allegany MD

24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502 ADDRESS

25a. DATE REC'D. BY REGISTRAR JAN 8 1986

25b. REGISTRAR'S SIGNATURE John Davidson

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2001 8/14

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Raymond M. Lobdell | | | 2a. DATE OF DEATH MONTH DAY YEAR 1-29-86 | | | 2b. HOUR 9⁴⁰ P M | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 9-17-17 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 68 | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Troy, New York | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Comm. Artist | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 3703 Evergreen Ave. 21206 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James Raymond Lobdell | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Main | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | 16b. SOCIAL SECURITY NO. WWII | | 17. INFORMANT Mrs. Edith B. Lockett | | ADDRESS Same as # 13e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-21 , 19 86 , to 1-29 , 19 86 , that (I) (we) lost saw the deceased alive on 1-29 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Daniel C. Hagan | | | | DEGREE D.O. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Daniel C. Hagan D.O. | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 1-30-86 | | 23c. NAME OF CEMETERY OR CREMATORY Westview | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. | | | | ADDRESS Baltimore, Md. | | 25a. DATE REC'D. BY REGISTRAR JAN 31 1986 | | 25b. REGISTRAR'S SIGNATURE J. Davidson-Randall | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified and advised.

1941

White

Belmont City

Local Hospital

Belmont

2103 Westwood Ave. - 2103

Belmont

Belmont

Belmont

Belmont

Belmont

Belmont

Belmont

Belmont, Mass. - 2103 Westwood Ave. - 2103

Belmont

Belmont

Belmont

Belmont, Mass.

Belmont

Belmont

Belmont

Belmont, Mass. - 2103 Westwood Ave. - 2103

007029

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01313

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) PHILIP | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR | | |
| 3. SEX Male | | | 4. RACE White | | | 5. DATE OF BIRTH MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Hosp. | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman | | | 12b. KIND OF BUSINESS OR INDUSTRY Gen. Motors | | |
| 13a. STATE Md. | | | 13b. COUNTY Baltimore | | | 13c. CITY OR TOWN Baltimore | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) Braggio | | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Rosalie | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 213-10-4649 | | |
| 17. INFORMANT Thomas Lonegro | | | 18. ADDRESS 1604 A Lancaster St. | | | 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | |
| 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | 20d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 20e. LOCATION STREET CITY OR TOWN COUNTY STATE | | | 20f. I certify that (I) (this hospital) attended the deceased from 12/30 , 19 85 , to 1/2 , 19 86 , that (I) (we) lost saw the deceased alive on 1/2/86 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | |
| 21a. SIGNATURE Joseph Braggio | | | 21b. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph Braggio | | | 21c. DATE SIGNED 1/2/86 | | | 21d. ADDRESS FSKMC 4940 Eastern Ave Balt. Md | | |
| 22a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 22b. DATE 1/4/86 | | | 22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | | | 22d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | | |
| 23. FUNERAL DIRECTOR NAME Lilly & Zeiler Inc. | | | 23b. ADDRESS 1901 Eastern Ave. | | | 23c. DATE REC'D. BY REGISTRAR JAN 3 1986 | | | 23d. REGISTRAR'S SIGNATURE | | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Cardiopulmonary Arrest**

DUE TO, OR AS A CONSEQUENCE OF

(b) **Sepsis**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

50700

A

CHIEFMAN

SO. COLL.

017125

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|------------------------------|--|--------------------------------|---|-------------------------------------|--|---------------------|---|--|--|--|
| 1- STATE REGISTRAR | | DECEASED NAME FIRST MIDDLE LAST JAMES O. LONG | | | | | | | | | | 2c. DATE KNOWN OF DEATH ESTIMATED 1-10-86 | | 2b. HOUR 9:00 PM | | | | | |
| 3 SEX male | | 4. RACE black | | 5. DATE OF BIRTH MONTH DAY YEAR 3 17 1934 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS. | | IF UNDER 1 YR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 2c. DATE PRONOUNCED DEAD 1-10-86 | | 2d. HOUR 9:00 PM | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Deaton Medical Center | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | | | | 12b. KIND OF BUSINESS OR INDUSTRY Beth Steel | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | | | | | | |
| 13a. STATE Md | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN Baltimore | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 4114 W. Rogers Avenue 21215 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Long | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Snow | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | | | | | 16b. SOCIAL SECURITY NO. 238-46-6699 | | | | 17. INFORMANT ADDRESS Lula M. Long 1325 Winston Avenue | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of abdomen with complications</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject shot | | | | 21c. LOCATION STREET CITY OR TOWN COUNTY STATE 1 Meriam Ct. Owings Mills, Maryland | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | | 21e. LOCATION STREET CITY OR TOWN COUNTY STATE apartment 1 Meriam Ct. Owings Mills, Maryland | | | | 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Margarita A. Korell, M.D. | | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | | | | | DATE SIGNED 1-11-86 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 1/16/86 | | | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co Md | | | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS William C. March F/H West 4300 Wabash Avenue | | | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 14 1986 | | | | 25b. REGISTRAR'S SIGNATURE | | | |

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

0111132

REEL 10010M FIBER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and immediately filed in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 4 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the result must be indicated above.

020255

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) JOHN R. LOOSEMORE | | | 2a. DATE OF DEATH MONTH DAY YEAR 11/16/86 | | 2b. HOUR 7:05 A.M. |
| 3. SEX MALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR OCT. 12, 1909 | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST VIRGINIA | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD. | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANCIS SCOTT KEY MED. CNTR. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CRANE OPERATOR | 12b. KIND OF BUSINESS OR INDUSTRY STEEL | |
| 13a. STATE MARYLAND | 13b. COUNTY BALTIMORE | 13c. CITY OR TOWN 21224 | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 7610 GOUGH STREET 21224 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST J. H. LOOSEMORE | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HANNAH REESE | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- | 17. INFORMANT ADDRESS GLORIA C. HUTSON 21204 8413 LOCH RAVENBLVD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aspiration pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) hypoxic encephalopathy | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days 2 yrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/14, 1986, to 11/16/86, that (I) (we) lost saw the deceased alive on 11/15, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Theodore MacKinney | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 11/16/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Theodore MacKinney | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE JAN. 18, '86 | 23c. NAME OF CEMETERY OR CREMATORY MORELAND MEM. PARK | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CO., MARYLAND | |
| 24. FUNERAL DIRECTOR NAME WILLIAM E. JOHNSON | | ADDRESS 8521 LOCH RAVEN BLVD. | | 25a. DATE REC'D. BY REGISTRAR JAN 16 1986 | 25b. REGISTRAR'S SIGNATURE |

BP

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RECEIVED

NOV 10 1964



[Faint, mostly illegible text and markings covering the main body of the document, possibly a form or ledger page.]

gold chord
ring 4th finger
right hand
020249

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01316

| | | | | | |
|--|---------|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | HOURS MIN. | |
| MARIE S. LOOSEMORE | | 01 15 86 | | 12 05 PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| FEMALE | WHITE | MONTH DAY YEAR | | 76 YRS. | |
| 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| MARYLAND | | U.S.A. | | City MD. | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| NORTH CHARLES GENERAL HOSPITAL | | MACHINE OPERATOR | | CLOTHES | |
| 13a. STATE | | 13b. CITY OR TOWN | | 13c. STREET ADDRESS / ZIP CODE | |
| MARYLAND | | BALTIMORE | | 21224 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | |
| JACOB | | KATIE | | NO | |
| 16b. SOCIAL SECURITY NO | | 17. INFORMANT | | 17. ADDRESS | |
| 218-01-3320 | | GLORIA C. HUTSON | | 21204 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) CHRONIC OBSTRUCTIVE LUNG DISEASE | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (b) ARTERIOSCLEROTIC HEART DISEASE | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) ACUTE CEREBRO-VASCULAR ACCIDENT | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| UREMIA. PARKINSON'S DISEASE. SIP RT. MASTECTOMY. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from | | 1-4-1986 | | to 1-15-1986 that (I) (we) last | |
| saw the deceased alive on | | 1-15-1986 | | and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| Sudhir D. Patel | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 1-15-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| SUDHIR D. PATEL | | NORTH CHARLES GEN HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| BURIAL | | JAN. 18, '86 | | MORELAND MEM. PARK | |
| 24. FUNERAL DIRECTOR | | 24a. DATE REC'D. BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | |
| WILLIAM E. JOHNSON | | JAN 16 1986 | | J. Anderson | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST. BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 4 hours after death. Pages 4 and 5 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|---|--|--|--|--|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PAUL BOWMAN LORD | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 11 1986 | | | 2b. HOUR M | | | |
| 3 SEX MALE | | 4 RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 9 22 10 | | 6 AGE (IN YEARS LAST BIRTHDAY) YRS 75 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) OHIO | | 7b CITIZEN OF WHAT COUNTRY? U.S. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10 CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WYMAN HEALTH SYSTEM | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) OFFICER | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. ARMY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND 13b COUNTY BALTIMORE 13c CITY OR TOWN 21204 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e STREET ADDRESS / ZIP CODE 1649 MUSSULA RD. 21204 | | | | | | | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST George H. Lord | | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NINA GREEN | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. II 281-03-6852 | | 17 INFORMANT ADDRESS EDWARD J. CAREY 2930 E. BALTIMORE ST. 21222 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (a) PONTINE AND LOWER MIND BRAIN HEMORRHAGE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Basilar artery occlusion (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 N/A | | | | | | | | | |
| 19a DATE OF OPERATION N/A | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A | | 20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERWAY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR N/A | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N/A | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK N/A | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.) N/A | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE N/A | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 1/10 , 19 86 , to 1/11 , 19 86 , that (I) (we) last saw the deceased alive on 1/10 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE P. Patel | | | | DEGREE M.B.Ch.B. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 1/11/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) PRAKASH. C. PATEL | | | | 22e ADDRESS WYMAN PARK DRIVE, BALTIMORE, MD. | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b DATE JAN. 15, '86 | | 23c NAME OF CEMETERY OR CREMATORY LAKE VIEW MEM. PARK | | 23d LOCATION CITY OR TOWN COUNTY STATE CARROLL COUNTY, MD | | | |
| 24 FUNERAL DIRECTOR NAME WILLIAM E. JOHNSON | | | | ADDRESS 8521 LOCH RAVEN BLVD. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 13 1986 | |
| | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |

MEDICAL CERTIFICATION

800810

022113

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M
 BP _____
 DHMH - 17
 (VR A15 ME (5))

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 01318 | |
|--|--|---|--|--|--|--|--|--|--|---|--|
| FOR 1- STATE REGISTRAR | | | | | | | | | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | | | | | | REG. NO. | |
| WALTER C. LOSIEWSKI | | | | | | | | | | 2a. DATE KNOWN OF DEATH 1-11-86 | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH 7 24 40 | | 6. AGE IN YEARS 45 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 2b. HOUR 3:35A | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) S.E. Police Station | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (Soc. Security) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 419 S. Durham St. 21231 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Walter C. Losiewski, Sr. | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Estelle Kozlowski | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | | 16b. SOCIAL SECURITY NO. 212-36-0067 | | 17. INFORMANT ADDRESS 122 N. Kenwood Ms. Rose Zebrowski Balto., Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hanging</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY 8:20AM 1-11-86 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject hanged self | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) cell #D-2 | | 21f. LOCATION S.E. Police Station Baltimore, Maryland | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Margareta DeGruel</i> | | | | M.D. Margarita A. Korell, M.D. | | | | TITLE (SPECIFY) Assistant | | DATE SIGNED 1-11-86 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS 111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | | | 23b. DATE 1/14/86 | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Anatomy Board Balto., Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 21 1986 | | 25b. REGISTRAR'S SIGNATURE | | | |



017143

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. CIVIL RECORDS, 1, 2, AND 3 TO THE FUNERAL DIRECTOR: PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

| Item# 23 C 23 D G 613 21/ 86 STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 01319 | |
|--|----------------------|--|---|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) WILLIAM E. LOVELIST | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 1-12-86 | | 2b. HOUR M | | | |
| 3. SEX Male | 4. RACE Negro | 5. DATE OF BIRTH MONTH DAY YEAR 11 24 50 | 6. AGE (IN YEARS LAST BIRTHDAY) 35 YRS. | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD 1-12-86 | | 2d. HOUR 7:35A | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4 N. Central Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE M.D. | | 13b. COUNTY City | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 521 Willow Ave 21212 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Willie Edward Lovelist | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Scott | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. 217-54-3440 | | 17. INFORMANT ADDRESS Alice Williams 521 Willow Ave 21212 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | 20. AUTOPSY? (HEAD ONLY) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on (HEAD ONLY) Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Margarita A. Korell | | | TITLE (SPECIFY) M.D. Assistant | | | MEDICAL EXAMINER | | DATE SIGNED 1-12-86 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | | ADDRESS 111 Penn Street | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-18-86 | | 23c. NAME OF CEMETERY OR CREMATORY Garrison Forest | | 23d. LOCATION CITY OR TOWN COUNTY STATE Young Mills, M.D. | | | | | |
| 24. FUNERAL DIRECTOR NAME Redd Funeral Home ADDRESS 5209 York Rd | | | | 25a. DATE REC'D. BY REGISTRAR JAN 14 1986 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | |

01-1710

CHICAGO

NOTION & CO.

WINTERHILL



CHICAGO

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---------|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 7b. HOUR | |
| JAMES F. LOWMAN | | January 2, 1911 | | 10:32 A.M. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Male | White | MONTH DAY YEAR 1-20-1911 | | 74 YRS. | |
| 7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7d. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| Ind. | | U.S.A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Baltimore | | Baltimore Hospital | | Clerk | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13b. STREET ADDRESS / ZIP CODE | |
| Grocery Store | | | | 2112 Baylawn Drive. 2123 | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) | | | |
| Ira Lowman | | Thomas Healey | | | |

| | | | |
|--|--------------------------|---------------|--------------------------|
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
| No | 215-09-5845A | Regina Lowman | 21227 2112 Gaylawn Dr |

| | | |
|---|--------------------------------|---|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY | | |
| IMMEDIATE CAUSE (a) | Cardiac Arrest | |
| DUE TO, OR AS A CONSEQUENCE OF | ASHD - Got Bleeding | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | (b) | |
| | DUE TO, OR AS A CONSEQUENCE OF | |
| | (c) Multiorgan Failure | |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

| | | | |
|------------------------|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
|------------------------|--|--|---|

| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY <table border="1"> <thead> <tr> <th>HOUR</th> <th>A.M.</th> <th>MONTH</th> <th>DAY</th> <th>YEAR</th> </tr> </thead> <tbody> <tr> <td></td> <td>P.M.</td> <td></td> <td></td> <td>19</td> </tr> </tbody> </table> | HOUR | A.M. | MONTH | DAY | YEAR | | P.M. | | | 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|--|-------|------|-------|-----|------|--|------|--|--|----|--|
| HOUR | A.M. | MONTH | DAY | YEAR | | | | | | | | |
| | P.M. | | | 19 | | | | | | | | |

| | | |
|---|---|---|
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NO! WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
|---|---|---|

22a. I certify that (I) (this hospital) attended the deceased from 28 DEC, 19 83, to 2 JAN, 19 86, that (I) (we) last saw the deceased alive on 28 DEC, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---------------------|---|------------------------------|
| 22b. SIGNATURE  | DEGREE [unclear] | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED Jan 1988 |
|---|---------------------|---|------------------------------|

| | |
|---------------------------------------|-----------------------|
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
| CURTIS EDWARDS | Box 500000s Hwy 24223 |

| | | | | | |
|--|----------|-----------------------------------|------------------------------|--------|-------|
| 23a BURIAL, CREMATION, REMOVAL (UIC 19-1) | 23b DATE | 23c NAME OF CEMETERY OR CREMATORY | 23d LOCATION CITY OR TOWN | COUNTY | STATE |
| Burial | 1-6-1986 | New Cemetery Co. | Galva | Tul | IL |

74 FUNERAL DIRECTOR ^(NAME) John J. Cowan & Son ADDRESS ^(ADDRESS) 21223 91st Hallins St. 25a DATE REC'D BY REGISTRAR JAN 8 1986 25b REGISTRAR'S SIGNATURE Julia Davidson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove cardiac copiers, Page 1 and 2, would be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner will be notified and advised.

MEDICAL CERTIFICATION

BP.

PT0610

VIA

BOX COLTON FIBER

THREE IN

ONE

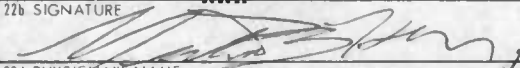
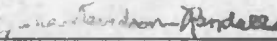


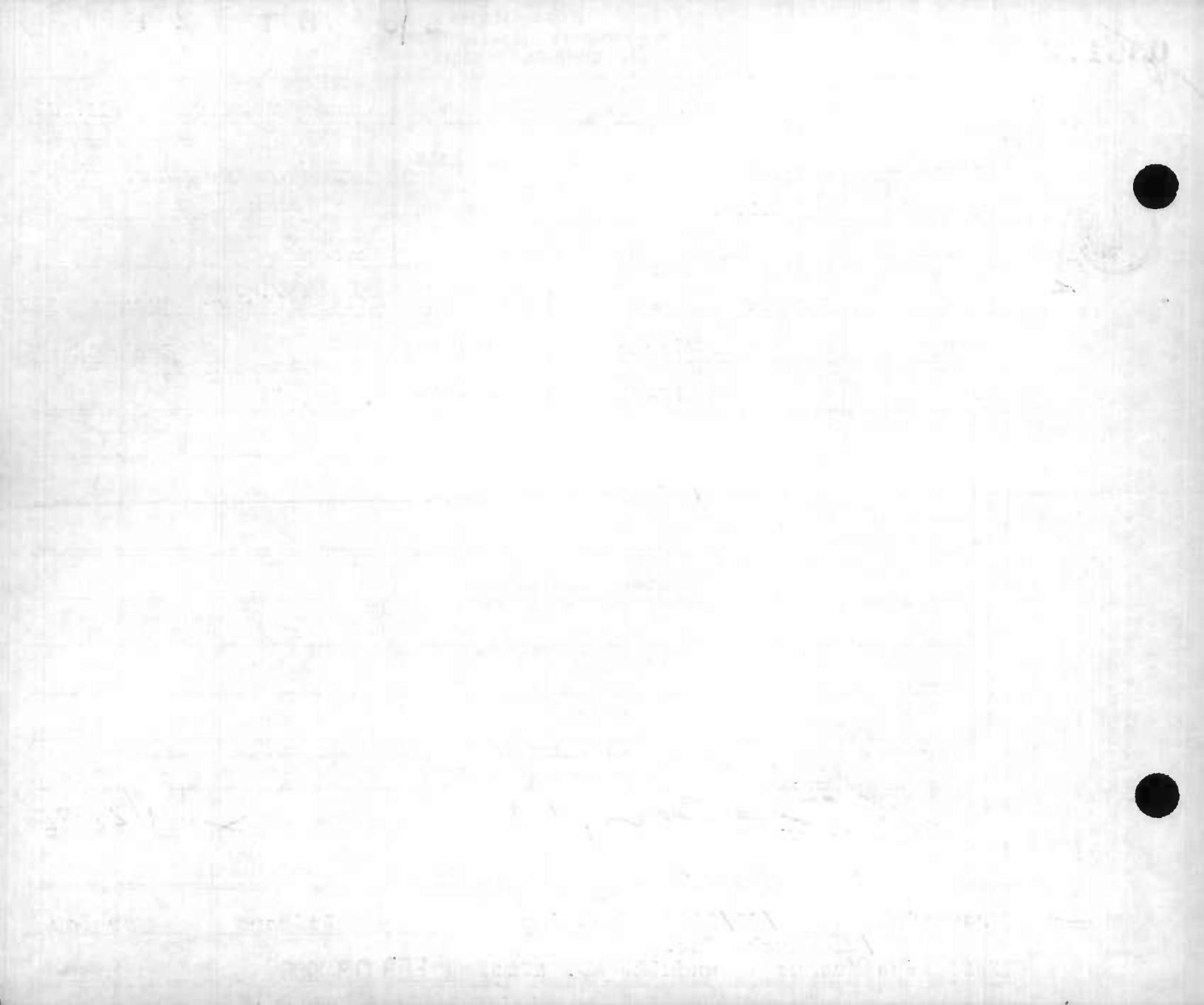
036172

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|--|---------------------------------------|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Dorothy G. LUDWIG | | | | 2a. DATE OF DEATH MONTH DAY YEAR January 28, 1986 | | | 2b. HOUR 11:20^{AM} | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 7 23 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 2924 Salisbury Avenue 21219 | | | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Edgemere | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Mitchell | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Lachoff | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-01-6129 | | 17. INFORMANT ADDRESS Same as 13e' Christian L. Ludwig | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intractable Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Diabetes Mellitus | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from January 13, 1986 , to January 28, 1986 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on January 28, 1986 and that in (my) <input checked="" type="checkbox"/> (we) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE  | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 1/28/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Herr, M.D. | | | | 22e. ADDRESS c/o Maryland General Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 1/31/1986 | | 23c. NAME OF CEMETERY OR CREMATORY Westview | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222 | | | | | | 25a. DATE REC'D. BY REGISTRAR FEB 03 1986 | | 25b. REGISTRAR'S SIGNATURE  | |



039093

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|--|---|---|---------------------------|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) ROLAND LUNN | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1-25-86 | | 2b. HOUR 9:05 A | | |
| 3. SEX M | | 4. RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR 12 13 08 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) md | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE md | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Robert Lunn | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lelia McClendon | | 13e. STREET ADDRESS, ZIP CODE 1517 N. Pulaski St. 21217 | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-05-3380 | | 17. INFORMANT ADDRESS Daisy Lunn 1517 N. Pulaski St. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CACHEXIA DUE TO, OR AS A CONSEQUENCE OF (b) CANCER OF PROSTATE DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a DEHYDRATION | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-23 , 19 86 , to 1-25 , 19 86 , that (I) (we) last saw the deceased alive on 1-25 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE BICH T DUONG | | | | DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 1-25-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BICH T DUONG | | | | 22e. ADDRESS LUTHERAN HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-29-86 | | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Bailey-Douglass Funeral Home | | | | ADDRESS 1348 N. Calhoun St. | | 25a. DATE REC'D BY REGISTRAR JAN 27 1986 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

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024129

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ESTHER LUWISHER | | | 2a. DATE OF DEATH MONTH DAY YEAR 01 17 86 | | | 2b. HOUR 12 noon | |
| 3. SEX FEMALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR 02 09 04 | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST LOUIS FRIEDMAN | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EVA MIRVIS | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | | |
| 16b. SOCIAL SECURITY NO. 212-44-8214 | | 17. INFORMANT MISS REBECCA LUWISHER 4009 ROSECREST AVE. BALTO., MD 21215 | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

HYPOTENSION, SEPTIC SHOCK

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Abdominal aortic aneurysmectomy

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-13-85 to 1-17-86 , that (I) (we) last saw the deceased alive on 1-17-86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Meenakshi Patel | | DEGREE MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1-17-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MEENAKSHI PATEL | | 22e. ADDRESS SINAI HOSPITAL | | | | | |

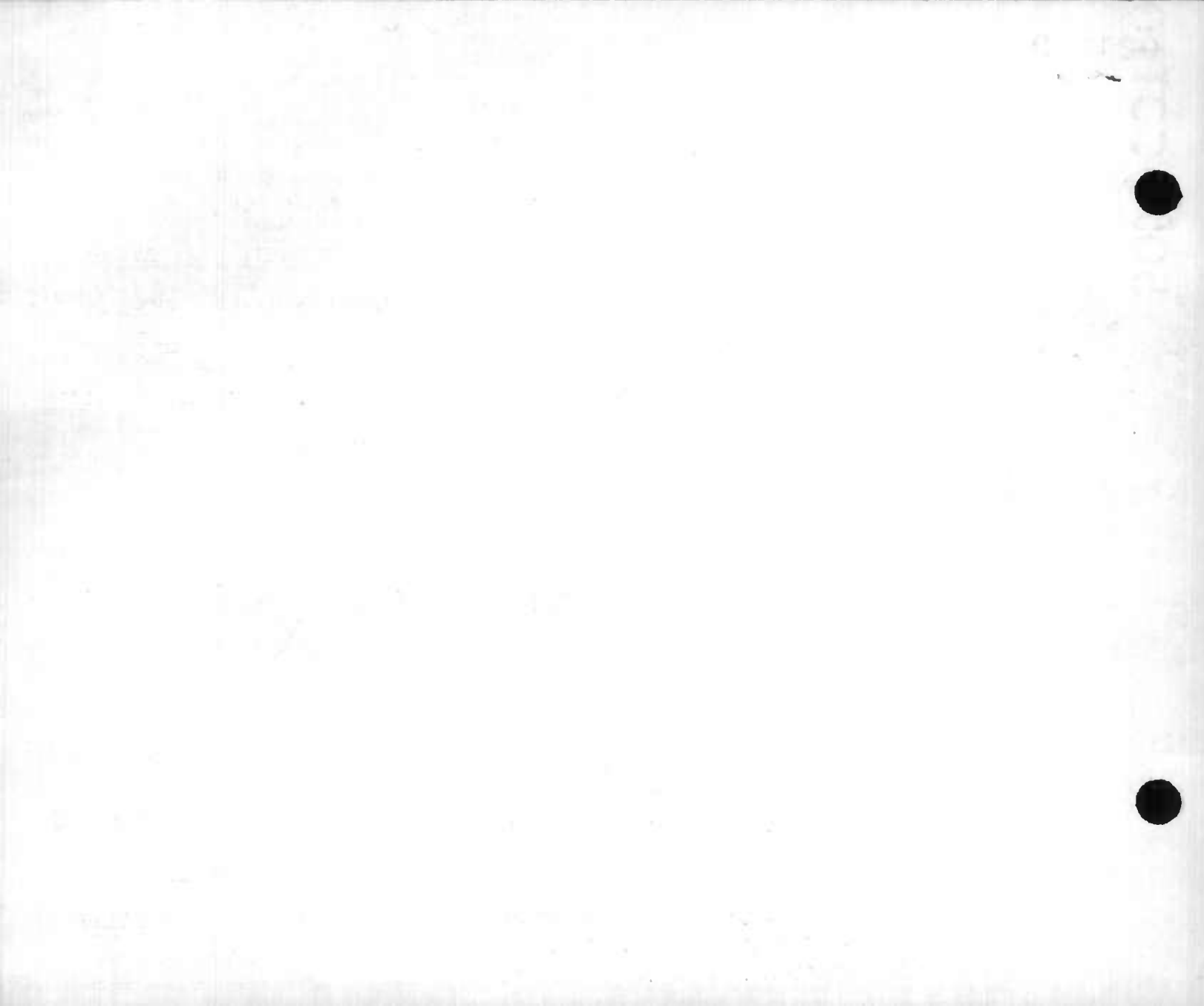
| | | | | | | | |
|--|--|-----------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE JAN. 19, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY BNAI ISRAEL | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | |
| 24. FUNERAL DIRECTOR NAME ADDRESS SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the law, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



016065

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|---|---|--|--|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Myrtle Lyles</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>1-11-86</i> | | | 2b. HOUR <i>5:30 PM</i> | | | |
| 3 SEX <i>FEMALE</i> | | 4 RACE <i>BLACK</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>10 06 05</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>80</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 72 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTIMORE CITY</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH <i>BALTIMORE</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>LUTHERAN HOSPITAL</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOMEMAKER</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>HOME</i> | |
| 13a. STATE <i>MARYLAND</i> | | | | 13b. COUNTY <i>BALTIMORE</i> | | 13c. CITY OR TOWN <i>BALTIMORE</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>SAMUEL TYNES</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>ADA B. ROSS</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No.</i> | | 16b. SOCIAL SECURITY NO. <i>218-10-4438</i> | | 17. INFORMANT <i>5305 Chrysler Avenue Baltimore, Maryland 2107</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gram negative Septicemia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Right lung atelectasis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cardiac arrhythmia</i> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/11/85</i> to <i>1/11/86</i> , that (I) (we) last saw the deceased alive on <i>1/11/86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>[Signature]</i> DEGREE | | | | | | 22c. DATE SIGNED <i>1/14/86</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Moges Gebremariam</i> | | | | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | | 23b. DATE <i>1/15/1986</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Baltimore National Cem.</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Maryland</i> | | |
| 24. FUNERAL HOME OR PERSONAL SERVICE NAME ADDRESS <i>NEFF & SONS FUNERAL HOME, INC. 2501 GWYNNS FALLS PKWY. BALTIMORE, MD. 21216</i> | | | | | | 25a. DATE REC'D. BY REGISTRAR <i>JAN 13 1986</i> | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be procured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the law, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 10 and 11 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

01325

| | | | | | | | | | | | |
|--|--|---|---|---|--|--|---|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <u>Lyons, Ruth</u> | | | 2a. DATE OF DEATH MONTH <u>1</u> DAY <u>11</u> YEAR <u>86</u> | | | 2b. HOUR <u>5:10A</u> | | | | | |
| 3 SEX <u>Fe</u> | | 4 RACE <u>B</u> | | 5. DATE OF BIRTH MONTH <u>5</u> DAY <u>1</u> YEAR <u>1919</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>66</u> YRS | | IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u> | | IF UNDER 24 HRS HOURS <u></u> MIN. <u></u> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>N.C.</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>CITY</u> MD | | | | | |
| 10. CITY OR TOWN OF DEATH <u>Balto</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Francis Scott Key</u> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>WAITRESS</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>RESTAURANT</u> | | | |
| 13a. STATE <u>Md.</u> | | | 13b. COUNTY <u>B. Ho</u> | | 13c. CITY OR TOWN <u>TURNERS</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE <u>325 Pine St. 21222</u> | | |
| 14. FATHER'S NAME FIRST <u>Eissi</u> MIDDLE <u></u> LAST <u>Gupton</u> | | | | 15. MOTHER'S MAIDEN NAME FIRST <u>NORA</u> MIDDLE <u>Shaw</u> LAST <u></u> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u> | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>242 24 0273</u> | | 17. INFORMANT <u>George Lyons</u> | | ADDRESS <u>325 Pine St. 21222</u> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiomyopathy</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>complication of myocardial infarction</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>reaction of myocardium & complications: hydropneumothorax VP shunt & adrenal hypofunction</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION <u>1/6</u> | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u></u> | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u></u> P.M. <u>19</u> | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/6</u> , 19 <u>86</u> , to <u>1/10</u> , 19 <u>86</u> , that (I) (we) (us) saw the deceased alive on <u>1/10/86</u> , 19 <u></u> , and that in (my) (our) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Brenda W. Cooper MD</u> | | | | | | DEGREE <u>MD</u> | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <u>1/13/86</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Brenda W. Cooper, MD</u> | | | | | | 22e. ADDRESS <u></u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | | 23b. DATE <u>1-15-86</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u> | | | 23d. LOCATION CITY OR TOWN <u>Balto.</u> COUNTY <u>Md.</u> STATE <u></u> | | | |
| 24. FUNERAL DIRECTOR NAME <u>JAS. A. MORTON & SONS</u> ADDRESS <u>1701 Laurens</u> | | | | | | 25a. DATE REC'D. BY REGISTRAR <u>JAN 16 1986</u> | | 25b. REGISTRAR'S SIGNATURE <u>J. Davidson</u> | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | |
|--|---------|--|--|---|--|---|--|----------------------------|--|--------------------------------|--|-------|--|------|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| ROY | | M. | | MACAULEY | | MACAULEY | | 1-25-86 | | 19 | | | | | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | |
| Male | White | 9-4-22 | | 63 YRS. | | | | | | 1-27-86 | | 19 | | | | 5:17P | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| Balto. Md. | | U.S.A. | | | | Baltimore City | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Baltimore | | 4212 Arizona Avenue 21206 | | Retired | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | |
| Md. | | | | Balto. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 4212 Arizona Ave.-21206 | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| Roy C. Macauley | | Louise Kossman | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| Yes | | 216-14-4004 | | Franklin C. Macauley | | 723 S. Charles St. 21206 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> . | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | alcoholism | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | | | | | | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | TITLE (SPECIFY) | | DATE SIGNED | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Margaret A. Korell</u> | | M.D. Assistant MEDICAL EXAMINER | | 1-28-86 | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | | | | | | | | |
| Margarita A. Korell, M.D. | | 111 Penn Street | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN | | COUNTY | | STATE | | | | | | | |
| Burial | | 1-30-86 | | Meadowridge Memorial Park | | Elkridge Md. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| John C. Miller Inc. | | 6415 Belair Rd.-21206 | | JAN 29 1986 | | John C. Miller | | | | | | | | | | | |

RECEIVED 1952

1-1-52
Franklin, (Account 75) J. (Order 1)
Ladies Room

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01327

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|---|---|--------|---|---|---|-----------------------------------|--|-----------|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR |
| Morris | | | | Macht | 1 | 23 | 86 | | 4:28 P.M. |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | |
| Male | Caucasian | 8 28 08 | | 77 | MONTHS | | DAYS | | HOURS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| POLAND | USA | | | Baltimore city MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL RESIDENCE (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | Sinei Hosp of Balt | | | | RESEARCHER XXXXXXXXXX | | SCIENCE | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | |
| Md. | | | | Baltimore | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 6511 Western Run Dr. 21215 | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | | | | | |
| BERYL | | MACHT | | MIRIAM UNKNOWN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | 18. ADDRESS | | | |
| NO | | | | MRS. BERNICE MACHT | | 6511 WESTERN RUN DR. #21215 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I. DEATH WAS CAUSED BY: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| IMMEDIATE CAUSE (a) | | Ventricular Fibrillation | | Immediate | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | (b) Ventricular aneurysm | | 2 years | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (c) Atherosclerotic Heart Disease | | ? | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (myself) attended the deceased from 9-15, 19 83, to 1-23, 19 86, that (I) (we) lost saw the deceased alive on 12-18, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | 22c. DATE SIGNED | | | |
| Warren Israel MD | | MD | | | | 1/23/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | |
| WARREN ISRAEL MD | | 8417 Bellona La Ste 10/ Baltimore, Md. 21204 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| BURIAL | | JAN. 26, 1986 | | BETH ISAAC ADATH ISRAEL | | BALTIMORE MARYLAND | | | |
| 24. FUNERAL DIRECTOR | | NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| SOL LEVINSON & BROS., INC. | | | | | | JAN 29 1986 | | | |
| 6010 REISTERSTOWN RD. BALTO., MD | | 21215 | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

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21
22



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) CHARLES O'DONNELL MACKALL | | | 2a. DATE OF DEATH MONTH DAY YEAR 130-86 7 58 P M | | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 1, 1881 | 6. AGE (IN YEARS LAST BIRTHDAY) 104 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH Balto. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Keswick Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) District Mgr. | | 12b. KIND OF BUSINESS OR INDUSTRY Auto Club |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE MD | 13b. COUNTY | 13c. CITY OR TOWN Balto. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 700 W. 40th St., 21211 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles Mackall | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Mackenzie | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Sp.-Amer. 218 22 8128 | 17. INFORMANT ADDRESS Harrison M. Robertson, Jr., Balto., MD | | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u> |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u> | | <u>20 YRS.</u> |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

| | | | |
|--|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (H) (this hospital) attended the deceased from <u>9-12</u> , 19 <u>74</u> , to <u>JAN 30</u> , 19 <u>86</u> , that (we) last saw the deceased alive on <u>JAN 30</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE <u>John F. Hartman, M.D.</u> | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED <u>1-30-86</u> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JOHN F. HARTMAN, M.D.</u> | | 22e. ADDRESS <u>Keswick N.H. 700 W 40th St BALTO. MD.</u> | |

| | | | |
|--|---------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 2/3/86 | 23c. NAME OF CEMETERY OR CREMATORY Green Mount | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto., MD |
| 24. FUNERAL DIRECTOR NAME ADDRESS Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212 | | 25a. DATE REC'D. BY REGISTRAR FEB 05 1986 | 25b. REGISTRAR'S SIGNATURE |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

016108

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 6 - 0 1 3 2 9

| | | | | | |
|---|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN M. M. MACKENZIE | | | 2a. DATE OF DEATH MONTH DAY YEAR January 10, 1986 | | 2b. HOUR 10A M |
| 3 SEX Male | 4 RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 21, 1902 | 6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | 7b. CITIZEN OF WHAT COUNTRY? USA | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | |
| 10 CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 104 W. University Pkwy. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Architect | 12b. KIND OF BUSINESS OR INDUSTRY Architecture | |
| 13a. STATE MD | 13b. COUNTY | 13c. CITY OR TOWN Balto. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 104 W. University Pkwy. 21210 | |
| 14 FATHER'S NAME FIRST MIDDLE LAST George M. MacKenzie | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Roberta Maynadinor | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215 10 0327 | | 17 INFORMANT ADDRESS C. Austin McDonnell, Jr., Towson, MD | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>over</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 m 30 y |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>Pt. has had 3 definite Coronaries in past 30 yr.</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Apr 19 1954</u> to <u>1/10 19 86</u> that (I) <u>was</u> lost saw the deceased alive on <u>10/29 19 85</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (If <u>two</u> (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Norman R. Freeman, Jr.</u> | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>1/10/86</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Norman R. Freeman, Jr., MD | | 22e. ADDRESS 4300 N. Charles St., Balto., MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 1/14/86 | 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge | | 23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville, MD | |
| 24 FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212 | | 25a. DATE REC'D. BY REGISTRAR JAN 13 1986 | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | |
|--|--|----------------|----------------|---|--|---|--|---|----------------|--|--|--|--|---|-----------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST James | | | MIDDLE U. | | | LAST Mackey | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 1 5 19 86 | | | 2b. HOUR M 9:57P M | | |
| 3. SEX Male | | 4. RACE QOL | | 5. DATE OF BIRTH MONTH DAY YEAR Nov 4, 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 8 19 86 | | | 2d. HOUR M | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 633 N. Aisquith | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Maryland | | | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 633 N. AISQUITH ST 21202 | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Willis Mackey | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Moore | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 241 037060 | | | | 17. INFORMANT ADDRESS Miss Denise Mackey 214 W. North Ave 21216 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Dennis F. Smyth</i> | | | | TITLE (SPECIFY) M.D. Assistant | | | | MEDICAL EXAMINER | | | | DATE SIGNED 1/9/86 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | Dennis F. Smyth, M.D. | | | | ADDRESS 111 Penn St. | | | | Balto. MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 1-13-86 | | 23c. NAME OF CEMETERY OR CREMATORY ARCADUS MEM PK | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO CO. MD | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Jas. L. Russ | | | | ADDRESS 2222 W NORTH AVE | | | | 25a. DATE REC'D. BY REGISTRAR JAN 17 1986 | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |

MEDICAL CERTIFICATION

510130

100% COTTON FIBER



031185

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|---|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) GRACE G. MADISON | | | 2a. DATE OF DEATH MONTH DAY YEAR January 23, 1986 | | | 2b. HOUR 8:55 AM | | | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR August 24, 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Inglennook Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Own home | |
| 13a. STATE Maryland | | 13b. COUNTY Anne Arundel | | 13c. CITY OR TOWN Glen Burnie | | 13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 292 Mackintosh Drive 21061 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Julius W. Stommel | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ellen Franklin | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214 74 2511 | | 17. INFORMANT ADDRESS Mary E. Snodgrass Same as 13e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ABDOMINAL CANCER DUE TO, OR AS A CONSEQUENCE OF with metastasis (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, HISTORY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER HISTORY OF INJURY IN FULL IN PART 2, OR PART 3) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, PARK, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/23/86 19 86 , to 1/23/86 19 86 , that (I) (we) last saw the deceased alive on above, (I) (we) (did) (did not) 1/23/86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | | | |
| 22b. SIGNATURE Mark Davis | | | | DEGREE | | 22c. DATE SIGNED 1/23/86 | | | |
| 22d. PHYSICIAN'S NAME Mark Davis | | | | 22e. ADDRESS 9051 Balto. Nat. Pike Ellicott City, Md. 21043 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1/25/86 | | 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Prince Georges Md. | | |
| 24. FUNERAL DIRECTOR Francis Gasch's Sons 4739 Baltimore Ave. Hyattsville, Md. 20781 | | | | | | 25a. DATE REC'D. BY REGISTRAR NAN 20 1986 | | 25b. REGISTRAR'S SIGNATURE | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____

DHMH - 16 50M 4/83
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the funeral director. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | |
|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <u>Stephen (STEVE)</u> | | | 2a. DATE OF DEATH MONTH DAY YEAR <u>JAN. 26, 1986</u> | | 2b. HOUR <u>12:47 PM</u> |
| 3. SEX <u>Male</u> | 4. RACE <u>White</u> | 5. DATE OF BIRTH MONTH DAY YEAR <u>September 13 1913</u> | 6. AGE (IN YEARS LAST BIRTHDAY) <u>72</u> YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Md.</u> | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>BALTIMORE CITY</u> MD. | | |
| 10. CITY OR TOWN OF DEATH <u>BALTIMORE</u> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>JOHNS HOPKINS HOSPITAL</u> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Tailor</u> | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE <u>Md.</u> | | 13b. COUNTY <u>Balto.</u> | 13c. CITY OR TOWN <u>Balto.</u> | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE <u>126 N. Kenwood Ave. 21224</u> |
| 14. FATHER'S NAME FIRST MIDDLE LAST <u>Peter Majka</u> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Pauline Skwirut</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u> | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>219-03-3244</u> | 17. INFORMANT ADDRESS <u>Stella Majka 126 N. Kenwood Ave.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ELECTROMECHANICAL DISSOCIATION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ischemic cardiac arrest</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>0</u> <u>30 min.</u> <u>1 yr.</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u> | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>January 19, 1986</u> to <u>January 26, 1986</u> , that (I) (we) last saw the deceased alive on <u>January 26, 1986</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.) | | | | | |
| 22b. SIGNATURE <u>Eric Brown MD</u> | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>1/26/86</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Eric Brown MD</u> | | 22e. ADDRESS <u>600 N WOLFE ST BALTO. MD. Johns Hopkins Hospital</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | 23b. DATE <u>1-30-86</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary</u> | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Balto. Md.</u> | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS <u>John M. Weber & Sons Inc. 401 S. Chester St.</u> | | 25a. DATE REC'D. BY REGISTRAR <u>JAN 28 1986</u> | | | |
| | | 25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u> | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Ethel M. Malachie | | | 2a. DATE OF DEATH MONTH DAY YEAR 1-7-86 | | | 7b. HOUR 9 40 A.M. | | | |
| 3. SEX Female | | 4. RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR 11 14 17 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) 1/14/17 | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |

| | | | | | | | | | | | | | | |
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| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | | 13b. COUNTY | | | 13c. CITY OR TOWN BALTIMORE | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE 3506 Manchester Ave 21215 | | |
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|--|--|--|---|--|--|
| 14. FATHER'S NAME FIRST MIDDLE LAST Levi — Mason | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha — Mason | | |
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|---|--|---|--|-----------------------------|--|---------------------------------------|--|
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) unknown | | 16b. SOCIAL SECURITY NO. 009-24-6886 | | 17. INFORMANT Ella Mason | | ADDRESS 3506 Manchester Ave. 21215 | |
|---|--|---|--|-----------------------------|--|---------------------------------------|--|

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Uncontrolled hypertensive crisis

| | | | | | | | |
|------------------------|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
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| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
|--|--|--|--|--|--|

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|--|--|--|--|---|--|
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
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|--|--|--|--|--|--|
| 22a. I certify that (I) (this hospital) attended the deceased from 1/7/85 to 1/7/85, that (I) (we) last saw the deceased alive on 1/7/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
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| 22b. SIGNATURE D. Lally MD | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/7/86 | |
|-------------------------------|--|--------|--|--|--|----------------------------|--|

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| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Denise Lally MD | | 22e. ADDRESS Sinai Hospital | |
|--|--|--------------------------------|--|

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|--|--|----------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/11/86 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | |
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| 24. FUNERAL DIRECTOR NAME Leroy O. Dyett | | ADDRESS 4600 Liberty Heights Ave. | | 25a. DATE REC'D. BY REGISTRAR JAN 9 1986 | | 25b. REGISTRAR'S SIGNATURE John Davidson-Rendell | |
|--|--|--------------------------------------|--|---|--|---|--|

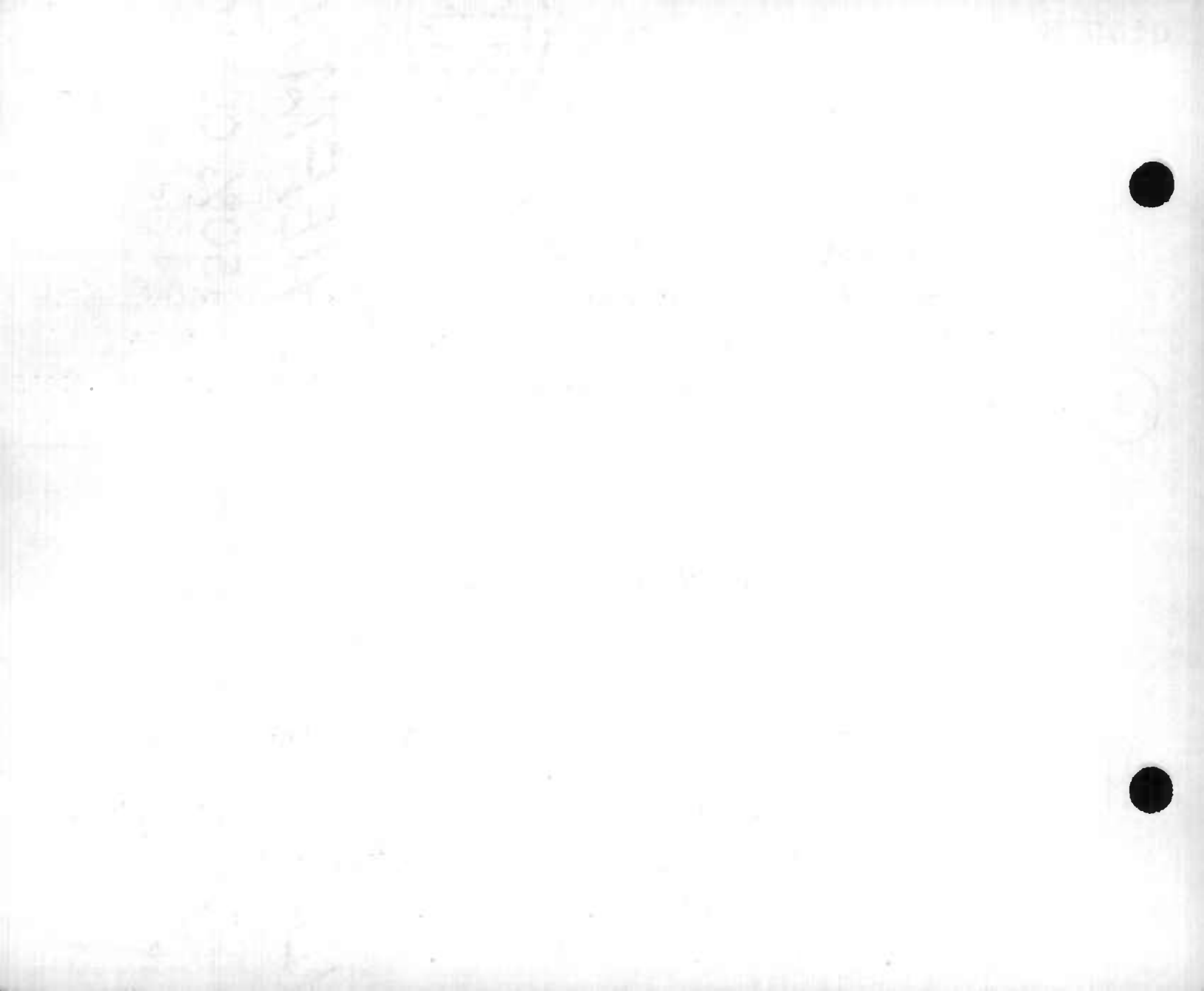
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|---|--|---|---|--|
| 1. FOR STATE REGISTRAR | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joanne Loretta Manning | | | January 25 1986 | | | 8 55 a.m. | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 12 21 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MAIN WORKING LIFE) unknown | | 12b. KIND OF BUSINESS OR COUNTRY Crown Crk. Seal. | |
| 13a. STATE Maryland | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Alexander Marecki | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hedwig Pakulski | | | 13e. STREET ADDRESS / ZIP CODE 316 Gusrayan St 21224 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-14-4262 | | 17. INFORMANT ADDRESS Alexander Marecki 5849 Arizona Ave. 21206 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac failure | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 21 hours | |
| DUE TO, OR AS A CONSEQUENCE OF (b) myocardial infarction | | | | | | | | 21 hours | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | |
| 19a. DATE OF OPERATION n/a | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR AM. MONTH DAY YEAR n/a | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, PARK, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/24 19 86 to 1/25 19 86, that (I) (we) last saw the deceased alive on 1/25 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Matthew Wagner | | | DEGREE MD | | | 22c. DATE SIGNED 1/25/86 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Matthew Wagner | |
| 22e. ADDRESS Mercy Hospital | | | Baltimore MD | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1-28-86 | | 23c. NAME OF CEMETERY OR CREMATORY Saint Stanislaus | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City Maryland | | |
| 24. FUNERAL DIRECTOR NAME Charles S. Zeiler & Son Inc. | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 27 1986 | | 25b. REGISTRAR'S SIGNATURE Julia E. Anderson | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) Katherine G.S. Marchant | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 3 86 | | 2b. HOUR 11 P.M. |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 1 9 1908 | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, City MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Long Green Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY Home | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Thomas C. Stringer | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE Katherine GUNTHER | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | 16b. SOCIAL SECURITY NO. 215-09-7875 | 17. INFORMANT ADDRESS Forest Hills N.Y. Anthony Hyde, Jr. 9963 66th. Ave. 11375 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary failure</u> DUE TO, OR AS A CONSEQUENCE OF b) <u>Chronic obstructive lung disease</u> DUE TO, OR AS A CONSEQUENCE OF c) <u>Arachnoid cyst - chronic</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 yr.</u> |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/16</u> 19 <u>85</u> to <u>1/3</u> 19 <u>86</u> , that (I) last saw the deceased alive on <u>12/31</u> 19 <u>85</u> , and that in (my) my opinion death occurred on the date and hour and from the causes stated above, (I) do not (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Norman R. Freeman</u> | DEGREE <u>M.D.</u> | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED <u>1/6/86</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Norman Freeman | | 22e. ADDRESS 4300 No. Charles St. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 1/8/86 | 23c. NAME OF CEMETERY OR CREMATORY United Methodist | 23d. LOCATION CITY OR TOWN COUNTY STATE Reisterstown Balto. Md. | | |
| 24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. | | ADDRESS 1050 York Rd. | 25a. DATE REC'D. BY REGISTRAR JAN 8 1986 | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Jack Tarson, Inc.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary A. Marinelli | | | | 2a. DATE KNOWN OF DEATH MONTH DAY YEAR 1/ 2/ 19 86 | | 2b. HOUR M P | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 6-15-1914 | | 6. AGE (IN YEARS) LAST BIRTHDAY 71 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | |
| 13a. STATE Md. | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John A. Marinelli | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary A. Marinelli | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ? | | 17. INFORMANT ADDRESS Hazel M. Burch - 876 W. Lombard St. 21201 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? HEAD ONLY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE [Signature] | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 1/3/86 | |
| EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. | | ADDRESS 111 Penn St. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 1-4-1986 | | 23c. NAME OF CEMETERY OR CREMATORY Notre Dame | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. Md. | |
| 24. FUNERAL DIRECTOR NAME [Signature] | | ADDRESS Baltimore, Md. 21223 | | 25a. DATE REC'D. BY REGISTRAR JAN 8 1986 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. ALL WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSIT PERMIT PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1/ FOR
STATE
REGISTRAR

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|---|--|--|--|---|---|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) KATHRYN J. MARING | | | 2a. DATE OF DEATH MONTH DAY YEAR January 18, 1986 | | 2b. HOUR M AM | | | | | | |
| 1. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR October 11, 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS 73 | | 7. IF UNDER 24 HRS. HOURS MIN. 73 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Roland Park Place Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Buyer | | 12b. KIND OF BUSINESS OR INDUSTRY Hutzler's | | | |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Ruxton 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE 906 Malvern Ave. 21204 | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James A. Montgomery | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude Emerich | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-07-0775 | | 17. INFORMANT ADDRESS Homer F. Maring - Same as #13e | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Colon Carcinoma DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11:10 19 86 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 5/1 , 19 85 , to 1/18 , 19 86 , that (1) (we) last saw the deceased alive on 1/18 , 19 86 , and that in my (our) opinion death occurred at the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Davis M. Hahn | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 1/20/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Davis M. Hahn, M.D. | | | | 22e. ADDRESS 5601 Loch Raven Blvd. Balto., Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment | | | 23b. DATE 1-21-86 | | 23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville, Balto., Md. | | | | |
| 24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Md. 21204 | | | | ADDRESS 1050 York Rd. | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 22 1986 | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01338

1. FOR
STATE REGISTRAR **Amelia C. Marsh**

REG. NO.

| | | | | | | | | | | |
|--|--|---|--|--|--|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Amelia C. MARSH | | | 2a. DATE OF DEATH MONTH DAY YEAR 1/2/86 | | | 2b. HOUR 1:55 P.M. | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 1/13/14 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC | | 9. CITIZEN OF WHAT COUNTRY? USA | | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD. | | | | |
| 12. CITY OR TOWN OF DEATH BALTIMORE | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Maryland Hospital | | | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 15. KIND OF BUSINESS OR INDUSTRY | | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Virginia | | | 13b. COUNTY Colonial Bch | | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13d. STREET ADDRESS / ZIP CODE 211 Nelson Street 99999 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Angelo Cellarelli | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Colobucci | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 579 12 9636 | | | 17. INFORMANT ADDRESS Colonial Beach, Virginia | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Suspected Pulmonary Embolism DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | |
| 19a. DATE OF OPERATION ____ | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/27 19 85 , to 1/2 19 86 , that (I) (we) last saw the deceased alive on 12/86 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Mark McBride MD | | | | | | DEGREE MD | | | 22c. DATE SIGNED 1/2/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARK MCBRIDE | | | | | | 22e. ADDRESS UNIV. OF MARYLAND HOSPITAL | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1/6/86 | | 23c. NAME OF CEMETERY OR CREMATORY Mt Comfort Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Balto. Md. 21225 George J. Gonce 4001 Ritchie Hwy | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 6 1986 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | |

MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|--|--|--|-------------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) CLYDE T. MARSHALL | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 29 '86 | | 2b. HOUR 6:48 P. M. | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 2 20 08 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS IF UNDER 1 YEAR: MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iowa | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH City Baltimore MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Maryland Cancer Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF PREVIOUS LIFE) Management | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | | 13b. COUNTY Baltimore | | 13c. STREET ADDRESS / ZIP CODE 5313 St. Albans Way 21212 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Arthur T. Marshall | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Leta Flickinger | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes ! WW II | | 16b. SOCIAL SECURITY NO. 320-05-2622 | |
| 17. INFORMANT George E. Thomsen | | 17. ADDRESS 1723 Munsay Bld. 21202 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF b) prostatic Cancer DUE TO, OR AS A CONSEQUENCE OF c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-23 1986 , to 1-29 1986 , that (I) (we) last saw the deceased alive on 1-29 1986 , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated on the certificate. (If we did not view the body after death, so state.) | | | | | | | |
| 22b. SIGNATURE Hyong Park | | DEGREE | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Hyong Park | | 22e. ADDRESS University of Maryland Cancer Center 225 Greene St. Baltimore, MD | | 22f. DATE REC'D. BY REGISTRAR | | 22g. REGISTRAR'S SIGNATURE Johanna Davidson | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE Jan 31 1986 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland 21201 | |
| 24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. | | | | ADDRESS Baltimore, Maryland | | 25a. DATE REC'D. BY REGISTRAR FEB 03 1986 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director. Page 3 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 01340

FOR
1 - STATE
REGISTRAR

036045

| | | | | | | | | |
|---|--------|---|------------------------------------|--|--|---|--------------------------------|----------------------------------|
| 1 DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 20. DATE OF DEATH MONTH DAY YEAR | | 2b HOUR | |
| Dorothy | | M | | Martin | 1/27/86 | | 6:05 PM | |
| 3. SEX | 4 RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS | |
| Female | white | | 2 23 26 | | 59 YRS | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | |
| Md. USA | | USA | | | | Baltimore City MD | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY |
| Baltimore | | University of Maryland Hospital | | | | Packer | | Factory |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b COUNTY | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS / ZIP CODE | |
| MD | | | | Baltimore | | 322 S. Calhoun St. 21223 | | |
| 14 FATHER'S NAME (TYPE OR PRINT) | | 15 MOTHER'S MAIDEN NAME (TYPE OR PRINT) | | | | | | |
| William | | HEBLER | | Mary Schallert | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT ADDRESS | | | | |
| No | | 219-16-9828 | | John C. Martin 322 S. Calhoun St. 21223 | | | | |

| | | |
|--|--|---|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio pulmonary failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Sepsis</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

| | | | |
|---|---|---|---|
| 19a DATE OF OPERATION 1/24/86 | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED Gangrenous BKA stump | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 1/27 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I, we) did not view the body after death. | | 22b SIGNATURE Gordon M Telepan | |
| 22c PHYSICIAN'S NAME (TYPE OR PRINT) Gordon M Telepan | | 22e ADDRESS 22 S Greene St. Balt. MD | |
| 22d DEGREE M.D. | | 22f DATE SIGNED 1/27/86 | |

| | | | |
|---|-----------|--|---|
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b DATE | 23c NAME OF CEMETERY OR CREMATORY | 23d LOCATION CITY OR TOWN COUNTY STATE |
| burial | 1-31-1986 | Lake View Trns. Pk. | Baltimore Co. Md. |
| 24 FUNERAL DIRECTOR NAME | | 25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE | |
| John J. Conner & Son Inc. 901 Hollins St. Baltimore 21223 | | FEB 04 1986 | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

0300



FEB 04 1988

007012

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

01341

| | | | | | | | | |
|---|--|--|---|--|------------------------------------|--|------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| ROBERT M. MARTIN | | | 1/2/86 | | | 4:15 AM | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | | | 7. IF UNDER 1 YEAR | | |
| Male | White | Dec. 15, 1903 | 82 | | | MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | U.S.A. | | BALTIMORE | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BALTIMORE CITY | UNION MEMORIAL HOSPITAL | | Packer | | | Bendix | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | |
| Maryland | | | | | | Baltimore | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| Harry Clay Martin | | | Emma Adelaide Chesney | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | |
| Yes | | | Unknown | | | 213-10-4675 Gary E. Miller, 5906 Burgess Ave. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | |
| IMMEDIATE CAUSE (a) Sepsis | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Severe heel infection | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) NIDDM | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: HBP, 2 CVA's | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION | | |
| WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/> | | | | | | CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/5, 1985, to 1/2, 1986, that (I) (we) lost saw the deceased alive on 1/1, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | 22c. DATE SIGNED |
| Gustavo A. Gonzalez M.D. | | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 1/2/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | |
| GUSTAVO A. GONZALEZ M.D. | | | | | | UNION MEMORIAL HOSPITAL | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Burial | | | Jan. 4, 1986 | | Moreland Mem. Park | | Parkville, Balto., Md. | |
| 24. NAME OF FUNERAL HOME, INC. | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE |
| ROBERT C. ALTENBURG FUNERAL HOME, INC. | | | | | | JAN 3 1986 | | Gustavo A. Gonzalez |
| 6009 Harford Rd., Balto., Md. 21214 | | | | | | | | |

MEDICAL CERTIFICATION

29

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified if one is available.

01-1142

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR Taylor B MARTIN

| | | | | | |
|---|--|--|--|---|---|
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST TAYLOR B MARTIN | | | 2a. DATE OF DEATH MONTH DAY YEAR JAN 8 1986 | | 2b. HOUR 1-23 PM |
| 3 SEX Male | 4 RACE M W | 5. DATE OF BIRTH MONTH DAY YEAR 3 14 24 | 6 AGE (IN YEARS LAST BIRTHDAY) 61 | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 74 HRS. | |
| 7a. BIRTHPLACE STATE OR FOREIGN COUNTRY Virginia | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 10 CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Worker | 12b. KIND OF BUSINESS OR INDUSTRY Textile | |
| 13a. STATE Maryland | | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14 FATHER'S NAME FIRST MIDDLE LAST Taylor Martin | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary (Unknown) | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 223-22-6861 | 17 INFORMANT ADDRESS 21223 Elsie D Martin/326 S Stricker St/Balto Md | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SHOCK DUE TO, OR AS A CONSEQUENCE OF (b) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Obstructive Pulmonary disease | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Pneumonia, Mitral stenosis | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-17-85 to 1-8-86 , that (I) (we) lost saw the deceased alive on 1-8-86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) sign the body after death. | | | | | |
| 22b. SIGNATURE Sambandan Sankaran | | DEGREE M.D. | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1-8-86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SAMBANDAN SANKARAN | | 22e. ADDRESS 3455 Wilkens Ave, Baltimore MD 21229 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 01/13/86 | 23c. NAME OF CEMETERY OR CREMATORY Crestlawn Gardens | | 23d. LOCATION CITY OR TOWN COUNTY STATE Howard County, Maryland | |
| 24 FUNERAL DIRECTOR NAME Walters Funeral Home/Pratt & Stricker Streets | | ADDRESS Balto Md 21223 | | 25a. DATE REC'D BY REGISTRAR JAN 10 1986 25b. REGISTRAR'S SIGNATURE | |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

01-11-10

ITALIA



ITALIA

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

036010

FOR
1- STATE
REGISTRAR

| | | | | | | |
|--|--|--|---|---|----------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) Frank (FRANCIS) J. MASANIELO | | | 2a. DATE OF DEATH MONTH DAY YEAR JAN. 31, 1986 | | 2b. HOUR 9:04P M | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR June 7, 1914 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS 71 | | 8. IF UNDER 24 HRS HOURS MIN. 71 | | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 10. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | |
| 12. CITY OR TOWN OF DEATH BALTIMORE | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) self employed | | |
| 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 15a. STATE Maryland | | 15b. COUNTY Baltimore | | 15c. CITY OR TOWN Baltimore | | |
| 16. FATHER'S NAME FIRST MIDDLE LAST Anthony Masaniello | | 17. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Antoinette Varella | | 18. STREET ADDRESS / ZIP CODE 238 South Eaton St. 21224 | | |
| 19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 20. SOCIAL SECURITY NO. 220-01-1893 | | 21. INFORMANT ADDRESS 21218 | | |
| 22. NAME OF DECEASED Connie Jones | | 23. ADDRESS 4100 N. Charles St. | | 24. ZIP CODE 21218 | | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiopulmonary arrest | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 35 minutes |
| DUE TO, OR AS A CONSEQUENCE OF (b) pulmonary embolus | | 6 hours |
| DUE TO, OR AS A CONSEQUENCE OF (c) venous thromboembolism | | unknown |

| | | | |
|---|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a ischemic cardiomyopathy | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21e. LOCATION STREET CITY OR TOWN COUNTY STATE | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-24 19 86 to 1-31 19 86 , that (I) (we) last saw the deceased alive on 1-31 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22a. SIGNATURE B. Brasfield | | 22b. DEGREE MD | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT) B. Brasfield | | 22d. ADDRESS JOHNS HOPKINS HOSPITAL 600 N WOLF ST 21205 | |

| | | | | | | | |
|---|--|------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL BURIAL | | 23b. DATE 2-4-1986 | | 23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus | | 23d. LOCATION OR TOWN COUNTY STATE Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Joseph N. ZANNINO JR. 263 South Conkling St. 21224 | | | | 25. DATE REC'D BY REGISTRAR FEB 03 1986 | | 26. REGISTRAR'S SIGNATURE [Signature] | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP
DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be attached to the funeral director's certificate of burial or cremation. The funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 of 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|---|---|---|--|--|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) JOSEPHINE T. MASCARI | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 28 1986 | | | 2b. HOUR 3:58 am | | | |
| 3. SEX FEMALE | | 4. RACE CAUC. | | 5. DATE OF BIRTH MONTH DAY YEAR 12 09 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 78 | | IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN. 3:58 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHURCH HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY RALEIGH CLOTHES | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH MASCARI | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST THERESA LAZZARO | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 215-01-8818 | | 17. INFORMANT ADDRESS MR. VINCENT J. MASCARI - 1401 ANGLESEA ST. APT 2C | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC ILLNESS DUE TO, OR AS A CONSEQUENCE OF (c) UNKNOWN NEUROLOGICAL SYNDROME | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: UNKNOWN NEUROLOGICAL SYNDROME | | | | | | | | | |
| 19a. DATE OF OPERATION JANUARY 19 1986 | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN FINDING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JANUARY 19 1986 to JANUARY 28 1986 , that (I) (we) last saw the deceased alive on JANUARY 28 1986 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE GARY KRIH | | | | DEGREE MD | | | | 22c. DATE SIGNED 1/28/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) GARY KRIH MD | | | | 22e. ADDRESS CHURCH HOSPITAL 100 N. BROADWAY, BALTIMORE, MD 21231 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 01-31-86 | | 23c. NAME OF CEMETERY OR CREMATORY HOLY REEDMER | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Walter Dabrowski - 1005 Dundalk Ave., 21224 | | | | 25a. DATE REC'D. BY REGISTRAR FEB 03 1986 | | 25b. REGISTRAR'S SIGNATURE J. Davidson-Randall | | | |

MEDICAL CERTIFICATION

29

 BP _____
 DHMH - 16 60M 7/84
 (VRA 15, 4)

 DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon copy of this certificate and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, this certificate must be verified at once.

3

Figure 1

13-00000

014084

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) EMMA M. MASON | | | 2a. DATE OF DEATH MONTH 01 DAY 09 YEAR 86 | | 2b. HOUR 10.25A |
| 3. SEX Female | 4. RACE black | 5. DATE OF BIRTH MONTH 1 DAY 18 YEAR 14 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH City | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed | | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 2115 Eting Street 21217 |
| 14. FATHER'S NAME FIRST Unknown MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST hucy MIDDLE LAST Boyd | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 213-26-7902 | | 17. INFORMANT ADDRESS Denise Manning 4412 Springdale Ave | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) OBSTRUCTIVE jaundice most likely due to Malignancy DUE TO, OR AS A CONSEQUENCE OF (b) Liver Abscess DUE TO, OR AS A CONSEQUENCE OF (c) Senile Dementia | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: NO | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 111 85 01/09 86 | |
| 22a. I certify that (I) (the hospital) attended the deceased from 1/9 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Kuang-Yen Huang | | DEGREE M.D. | | 22c. DATE SIGNED 1/10/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) KUANG-YEN HUANG | | 22e. ADDRESS Bon Secours Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/13/86 | | 23c. NAME OF CEMETERY OR CREMATORY Mt Auburn Cemetery | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md | | 23e. DATE REC'D. BY REGISTRAR JAN 10 1986 | | | |
| 24. FUNERAL DIRECTOR NAME William C. March F/H West 4300 Wabash Avenue | | 24b. REGISTRAR'S SIGNATURE Johanna... | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

BP

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020028

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1000. IF A BURIAL-TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHWH - 17
(VR A15 ME (5))

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 01346 | |
|---|--|--------------------------------------|--|---|---|--|--|---|--|---|--|
| 1- FOR STATE REGISTRAR Unkn. #86-6 | | | | | | | | | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | |
| 1- DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST | | | | | | | | | | 2a DATE KNOWN OF DEATH ESTI-MATED | |
| RONALD MASON | | | | | | | | | | X MONTH DAY YEAR 1/ 9/ 1986 | |
| 3 SEX Male | | 4 RACE Black | | 5 DATE OF BIRTH MONTH DAY YEAR 1 20 1963 | | 6 AGE (IN YEARS) LAST BIRTHDAY 22 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b CITIZEN OF WHAT COUNTRY? U. S. A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City | | 2c DATE PRONOUNCED DEAD 1/ 9/ 1986 | | 2d HOUR 6:06 P M | |
| 10 CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4725 Reisterstown Rd.. | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cook | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a STATE Maryland | | | | | | | | | | 13b COUNTY | |
| 13c CITY OR TOWN Baltimore | | | | | | | | | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e STREET ADDRESS 2114 Boyd St. 21223 | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Ronald Mason, Sr. | | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Peggy Siler | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b SOCIAL SECURITY NO. 218-78-1919 | | 17. INFORMANT ADDRESS Peggy Siler 2114 Boyd St. Balto. 21223 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Wound of Chest Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b TIME OF INJURY HOUR XX MONTH DAY YEAR 5:50 P.M. 1/ 9/ 19 86 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot during altercation | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street | | 21f LOCATION CITY OR TOWN COUNTY STATE 4725 Reisterstown, Rd., Balto. City, Md. | | | | | |
| 22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Gregory R. Kauffman, M.D. | | | | TITLE (SPECIFY) Assistant | | | | DATE SIGNED 1/10/86 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. | | | | ADDRESS 111 Penn St. | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b DATE 1-16-86 | | 23c NAME OF CEMETERY OR CREMATORY Arbutus memorial park | | | | 23d LOCATION CITY OR TOWN COUNTY STATE Arbutus Maryland | |
| 24 FUNERAL DIRECTOR NAME Bailey-Douglass Funeral Home | | | | | | 25a DATE REC'D. BY REGISTRAR 1/16/86 | | | | | |
| ADDRESS 1348 N. Calhoun St. | | | | | | JAN 16 1986 | | | | | |

020023

100% COTTON LITE

WINTER 1963



JAN 18 1963

010117

DIVISION OF VITAL RECORDS, 201 W. PRESTON AVE., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. LONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MDHMH - 17
(VR A15 ME (5))1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|------------------|--------------------------------|---|-------------------------------|--------------------------------|---|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST ROBERT Edward MATHIS | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 4 19 86 | | | 2b. HOUR 3:50 A M | | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MAY 6 1965 | 6. AGE (IN YEARS) 20 YRS. | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7c. DATE PRONOUNCED DEAD 1 4 19 86 | | | 2d. HOUR 3:50 A M | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore Co., Md. | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital (STU) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk | | | 12b. KIND OF BUSINESS OR INDUSTRY Dept. Store | | |
| 13a. STATE Maryland | | | 13b. COUNTY Baltimore | | | 13c. CITY OR TOWN Essex | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Carl Mathis, Sr. | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Rahnis | | | 16. SOCIAL SECURITY NO. 212 80 1507 | | | 17. INFORMANT Anna Mathis, Mother | | |
| 18. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | 19. (IF YES, GIVE WAR OR DATES) - | | | 20. ADDRESS Same | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thoraco-abdominal trauma</u> 8151 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:35 1-4- 19 86 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Passenger of auto/fixed object impact. | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Carroll Island Rd. so. of, Essex, Balto. MD | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | | | DATE SIGNED 1-4-86 | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | ADDRESS 111 Penn St., Balto., MD 21201 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | | 23b. DATE 1/7/86 | | | 23c. NAME OF CEMETERY OR CREMATORY Holly Hill Memorial Gardens | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md. | | |
| 24. FUNERAL DIRECTOR Bruzdzinski Funeral Home PA 1407 Old Eastern Ave | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 8 1986 | | | 25b. REGISTRAR'S SIGNATURE | | |

MEDICAL CERTIFICATION

100% COTTON FIBRE

MADE IN U.S.A.

MADE IN U.S.A.



016102

STATE OF MARYLAND 0 0 1 3 4 8

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|---|---|--|---|--|---|----------|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | | 1 4 86 337 pm | |
| CATHERINE J. MATTHEWS | | | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| FEMALE | WHITE | MONTH DAY YEAR 12 - 21 - 28 | | 57 | | IF UNDER 24 HRS MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Co. Virg. | U.S.A. | | | BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | South Baltimore General | | Ret. Printing Co. | | | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | |
| MD | | Baltimore | | | Balto. Md. 21230 614 E. Fort Avenue | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | |
| George - Gallagher | | MARY JOE ROY | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | | |
| NO | | 2364 02023 | | 21230 ADDRESS 614 E. Fort Ave. OLD CHAIR Charles H. Matthews | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL ANOXIA DUE TO, OR AS A CONSEQUENCE OF (b) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (c) CEREBRAL EDEMA APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) OAT CARCINOMA OF LUNG | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/11/86 to 1/19/86, that (I) (we) last saw the deceased alive on 1/8/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE THOMAS K. GALVIN MD | | DEGREE MD | | 22c. DATE SIGNED 1/19/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| THOMAS K. GALVIN MD | | 3001 S. HANOVER ST. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | |
| Burial | | 1/11/86 | Cedar Hill Cemetery | | Balto. A.A. Co. Maryland | | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| McCully Funeral Home, 130 E. Fort Ave. | | Balto. Md. 21230 JAN 13 1986 | | | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

013131



COPIES OF COLLECTION

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "Baltimore" and "Maryland" are faintly visible.]

036176

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

01349

 1- FOR
 STATE
 REGISTRAR

REG. NO.

| | | | | | |
|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) MERRIE LILLIAN MATTHEWS | | | 2a. DATE OF DEATH MONTH DAY YEAR 1/30/86 | | 2b. HOUR 8:30 P.M. |
| 3. SEX FEMALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR 12/24/1909 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Penna. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MASON F. LOR | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland | | | 13b. CITY OR TOWN Baltimore | 13c. CITY OR TOWN Dundalk | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Abram G. Bachman | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen WHISTLER | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 202-20-6690 | | 17. INFORMANT ADDRESS Diane M. Knoch (Daughter) (Same as 13e) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL VASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF (c) 6 WEEKS | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 MIN |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1/17/86 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1/30/86 | |
| 22. I certify that (I, this hospital) attended the deceased from 1/17/86 to 1/30/86 , that (I) did saw the deceased alive on 1/30 19 86 , and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) did not examine the body after death. | | | | | |
| 22a. SIGNATURE Richard Bennett MD | | DEGREE MD | | 22c. DATE SIGNED 1/31/86 | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) Richard Bennett MD | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (CHECK) Burial | 23b. DATE 2/3/1986 | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Maryland | |
| 24. FUNERAL DIRECTOR Walter Brooks Bradley Inc., Dundalk, Md. 21222 | | | | 25a. DATE REC'D. BY REGISTRAR FEB 03 1986 | 25b. REGISTRAR'S SIGNATURE Juanita Wilson-Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

03015

EXHIBITION

10/11/11



016022

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|---|--|---|---|--|---|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) LILLIAN M MAULER | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 10, 1986 | | | 2b. HOUR A 10:30 M | | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR November 29, 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 203 N. Ellwood Ave. 21224 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Stanford | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mollie Scott | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 217-03-0010 | |
| 17. INFORMANT ADDRESS Dorothy Moricle 21205 /2909 E. Jefferson St. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>renal failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 minutes 30 days | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from <u>Dec 4</u> , 19 <u>85</u> , to <u>Jan 10</u> , 19 <u>86</u> , that (11) <u>we</u> lost saw the deceased alive on <u>Jan 10</u> , 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If you did not view the body after death, so state.) | | | | | | | | | | | |
| 22b. SIGNATURE <u>Robert Strump</u> | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 1-10-86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Strump | | | 22e. ADDRESS 600 North Wolfe Street, Baltimore, MD | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1/14/86 | | 23c. NAME OF CEMETERY OR CREMATORY Loudan Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City Maryland | | | | |
| 24. FUNERAL DIRECTOR NAME Lilly & Zeiler, Inc. / 1901 Eastern Ave. | | | ADDRESS 21231 | | | 25a. DATE REC'D. BY REGISTRAR JAN 13 1986 | | 25b. REGISTRAR'S SIGNATURE | | | |

BP

020020

20% COTTON

WINE

WINE



REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS PM 3, PM 4, AND PM 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL—TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 602 MA PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP_____

DHMH - 17

(VR A15 ME (5))

| | | | | | | | | | | | | | | | | | | | |
|--|--|---------|--|---|--|-------------------|--|---|--|------------------|--|---|--|---|--|--|--|-------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | | | |
| Gregory | | Alan | | May | | | | 1-19 | | 19 | | 86 | | | | 2:50 P. M. | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | |
| male | | white | | Dec. 11, 1954 | | 31 YRS. | | MONTHS | | DAYS | | HOURS | | MIN. | | 1-19 | | 19 86 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Maryland | | | | USA | | | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | Baltimore City, | | | | MD | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Baltimore | | | | Leakin Pk., west of 1100 blk. Hilton Parkway | | | | state trooper | | | | state gov. | | | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? | | | | 13e. STREET ADDRESS | | | |
| Maryland | | | | Washington | | | | Hagerstown | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | Cool Hollow Rd. Route 9 | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| Lloyd A. May | | | | Betty L. Hause | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | ADDRESS | | | | | | | |
| No | | | | 220-58-2793 | | | | Mrs. Pamela K. May, Hagerstown, Md. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Blunt Trauma to Chest | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? | | | | | |
| | | | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| | | | | 4:05 PM 1-19 19 86 | | | | pilot in helicopter crash | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | | | | | | | | |
| | | | | park | | | | west of 1100 blk. Hilton Parkway, Balto., Md. | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | | | | | | | DATE SIGNED | | | | | |
| Dennis F. Smyth, M.D. | | | | M.D. Assistant MEDICAL EXAMINER | | | | | | | | | | 1-20-86 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | | | | | |
| Dennis F. Smyth, M.D. | | | | 111 Penn St., Balto., Md. | | | | | | | | | | 21201 | | | | | |
| 23a. BURIAL CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | | | | | |
| burial | | | | Jan. 23, 1986 | | | | Rest Haven Cemetery | | | | Hagerstown, Wash., Maryland | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D, BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| MINNICH FUNERAL HOME | | | | 415 E. Wilson Blvd., Hagerstown, Md. 21740 | | | | JAN 27 1986 | | | | | | | | | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 01352
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | |
|--|---------|--|--|--|--|---|--|---|--|--------------------------------|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF ESTI- DEATH MATED | | MONTH DAY YEAR | | 2b. HOUR | |
| THOMAS | | F. | | MAY | | | | 1-18-86 | | | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| Male | White | 1-6-1908 | | 18 YRS. | | | | | | 1-21-86 | | 7:20A | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Md. | | U.S.A. | | WIDOWED | | DIVORCED | | Baltimore City | | | | MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Baltimore | | 1215 James Street - 21223 | | Baker | | Bakery | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| Md. | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1215 James St. 21223 | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| Thomas May | | Mary O'Brien | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | |
| Yes | | W.W.H. 213-12-3251 | | James W. May | | 10329 Globe Drive | | | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

MEDICAL CERTIFICATION

| | | | | | |
|---|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | |
| Margarita A. Korell, M.D. | | Assistant | | 1-21-86 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | |
| Margarita A. Korell, M.D. | | 111 Penn Street. | | | |

| | | | | | | | |
|--|--|-----------------|--|------------------------------------|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | 1-23-1986 | | New Cathedral Com. | | Baltimore City Md. | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| John J. Cronin & Son, Inc. | | 901 Hopkins St. | | JAN 27 1986 | | Julia Davidson-Randall | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, 4 AND 5 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

01353

| | | | | | | | | | | | | |
|--|--|---|--|---|--|--|---|---|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) CATHERINE M MAYNOR | | | 2a. DATE OF DEATH MONTH DAY YEAR 1-3-86 | | | 2b. HOUR 3:30 am | | | | | | |
| 3. SEX FEMALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 01 12 23 | | 6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY OF MD. HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE BALT. | | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN CITY | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 608 ROUNDVIEW ROAD 21225 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JUNIOUS — BROWN | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELER — BOULDIN | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-22-3764 | | 17. INFORMANT ADDRESS BEGONA ARISTIMUNO MD. / UMHS. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> 8199 DUE TO, OR AS A CONSEQUENCE OF (b) <u>END STAGE RENAL DISEASE, QUESTION HYPER- KALEMIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>S/P AFT AKA; QUESTION PULMONARY EMBOLISM</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>INFECTED LEFT KNEE w/ METH. RESISTANT STAPH. REQUIRING AKA.</u> | | | | | | | | | | | | |
| 19a. DATE OF OPERATION 01-01-86 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED LEFT INFECTED KNEE | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) MOTOR VEHICLE ACCIDENT | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) STREET / CAR | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>DECEMBER 27 1985</u> to <u>JANUARY 3 1986</u> that (I) (we) lost saw the deceased alive on <u>JANUARY 2 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE B. Aristimuno MD | | | DEGREE | | | 22c. DATE SIGNED 01-03-86 | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. ARISTIMUNO | | | 22e. ADDRESS UNIVERSITY OF MARYLAND HOSPITAL | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 1/7/86 | | 23c. NAME OF CEMETERY OR CREMATORY GARRISON FORREST | | 23d. LOCATION CITY OR TOWN COUNTY STATE OWINGS MILLS MD | | | | | |
| 24. FUNERAL DIRECTOR NAME WM. C. MARCH FUNERAL HOME 1101 E. NORTH AVE. | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 7 1986 | | 25b. REGISTRAR'S SIGNATURE John B. Swiden | | | | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M
 BP
DHMH - 17
(VR A15 ME (1))

 1- FOR
STATE
REGISTRAR

 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|---------|---|--------|--|---|---|------------------|---|--------------------------|--|
| DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2b. DATE KNOWN OF DEATH ESTIMATED | | MONTH | DAY | YEAR | 2d. HOUR |
| CLIFFORD LEE MAYO JR. | | | | | <input checked="" type="checkbox"/> 1 1 19 86 | | | | | M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | 2d. HOUR |
| M | B | 10 29 61 | | 24 YRS. | MONTHS DAYS HOURS MIN. | | | | 1 1 19 86 | 2:15 P.M. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| MARYLAND | | U.S.A. | | | | Baltimore City | | MD | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | | University Hospital | | | | N/A | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | |
| MARYLAND | | | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 915 N. ROSEDALE STREET 21216 | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| CLIFFORD MAYO SR. | | | | DIETRA MCALLEN | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | |
| NO | | | | 212-82-5966 | | CLIFFORD LEE MAYO SR. 915 N. ROSEDALE ST. BALTO. MD. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Gunshot wound of abdomen (handgun)</u> | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | |
| (b) <u>DUE TO, OR AS A CONSEQUENCE OF</u> | | | | | | | | | | |
| (c) <u></u> | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| | | | | 9:56 P.M. 12-31-1985 | | Subject shot. | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | | | |
| | | | | street | | 1300 blk. Bloomingdale Rd., Balto. City MD | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | |
| | | | | M.D. Assistant MEDICAL EXAMINER | | | | 1-2-86 | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | |
| Ann M. Dixon, M.D. | | | | 111 Penn St., Balto., MD 21201 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | | |
| BURIAL | | 1-7-86 | | ARBUTUS | | | ARBUTUS MARYLAND | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| WM.C.MARCH F/H INC. 1101 E. NORTH AVE. | | | | | | JAN 6 1986 | | | | |

20% COTTON FIBER

MADE IN U.S.A.



1-1-00

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

023006

2a DATE OF DEATH MONTH DAY YEAR 2b HOUR
1/17/86 11:20 PM

3 SEX Female 4 RACE White 5 DATE OF BIRTH MONTH DAY YEAR April 24, 1894

6 AGE (IN YEARS LAST BIRTHDAY) 91 7b CITIZEN OF WHAT COUNTRY? U.S.A. 8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.

10 CITY OR TOWN OF DEATH BALTIMORE 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Office Work US 12b KIND OF BUSINESS OR INDUSTRY Gov't Ret

13a STATE Maryland 13b COUNTY 13c CITY OR TOWN Baltimore 13d INSIDE CITY LIMITS? YES ☒ NO ☐ 13e STREET ADDRESS / ZIP CODE 4319 Marble Road 21218

14 FATHER'S NAME FIRST MIDDLE LAST Robert Alexander Cullison 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jennie Cullison

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No 16b SOCIAL SECURITY NO 214-03-0006 17 INFORMANT ADDRESS Thelma K. Smith 1531 Argonne Drive 21218

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CAROTID ARTERY
(b)
(c)
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0

19a DATE OF OPERATION 19b CONDITION FOR WHICH OPERATION WAS PERFORMED 20a AUTOPSY? YES ☐ NO ☒ 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d INJURY OCCURRED WHILE ☐ AT WORK NOT WHILE ☐ AT WORK 21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) 21f LOCATION STREET CITY OR TOWN COUNTY STATE

22a I certify that (I) (this hospital) attended the deceased from 1/7 19 86 to 1/17 19 86 that (I) (we) last saw the deceased alive on 1/17 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE L. I. KITCHIN DEGREE 22c DATE SIGNED 1/17/86

22d PHYSICIAN'S NAME (TYPE OR PRINT) L. I. KITCHIN 22e ADDRESS UNION MEMORIAL HOSPITAL

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b DATE Jan 20 1986 23c NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery 23d LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland

24 FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. ADDRESS Baltimore, Maryland 25a DATE REC'D. BY REGISTRAR JAN 21 1986 25b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a full examination must be conducted at once.

MEDICAL CERTIFICATION

023006

Division

11

April 24, 1954

Office

Room

X

U.S.A.

Office Work in Gov't Bldg

81212 Room 21212

X

Division

Division

Division

Division

Division

Division

81212 Room 21212 Division 21212

21-07-000

20

Division

Division

Division 21212

21-07-000

Division

Division 21212, Inc. Division 21212

009080

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|--|---|---|--|---|-----------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) Hazel Lee McCleary | | 2a. DATE OF DEATH MONTH DAY YEAR January 4, 1986 | | 2b. HOUR 12:07 PM | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 3/1/1920 | | 6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |

| | | | | | |
|--|--|---|---------------------------------------|---|---|
| 13a. STATE MD. | | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 914 E. Reservoir St. |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles Clark McClary | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | |
| 16b. SOCIAL SECURITY NO. 214-12-1571 | | 17. INFORMANT ADDRESS Oran McCleary 914 E. Reservoir St. | | | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

| | | | |
|---|--|---|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NO, (IF MEDICAL EXAMINER)) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |

22. I certify that (I, Dr. Tzong-Yueh Hwang) attended the deceased from December 26, 1985, to January 4, 1986, that (I, we) saw the deceased alive on January 4, 1986, and that in our opinion death occurred on the date and hour and from the causes stated above, (I, we) did not view the body after death.

| | | |
|---|--|------------------|
| 22b. SIGNATURE Tzong-Yueh Hwang | DEGREE MD. | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) HWANG, TZONG-YUEH | 22e. ADDRESS c/o Maryland General Hospital | |

| | | | |
|--|----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (TYPE IF) | 23b. DATE 1/8/86 | 23c. NAME OF CEMETERY OR CREMATORY St. Ambrose C. | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD. |
| 24. FUNERAL DIRECTOR NAME ADDRESS Carroll 1212 W. North Ave | | 25a. DATE REC'D. BY REGISTRAR JAN 7 1986 | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the nonpopers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION



007016

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

01351

| | | | | | | | | |
|--|---|---|--|--|--|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| FIRST MIDDLE LAST <i>James McClellan</i> | | | MONTH DAY YEAR <i>1 1 86</i> | | | HOURS MIN. <i>2:12 PM</i> | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | |
| <i>Male</i> | <i>Black</i> | MONTH DAY YEAR <i>9 16 28</i> | <i>63</i> YRS. | | | MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | |
| <i>Maryland</i> | <i>USA</i> | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>City</i> MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| <i>Baltimore</i> | <i>Univ. of Maryland Cancer Center</i> | | | | <i>Trapper's Co.</i> | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13b. INSIDE CITY LIMITS? | | | 13c. STREET ADDRESS / ZIP CODE | | |
| STATE CITY OR TOWN <i>MD Baltimore Baltimore</i> | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | <i>2814 Walbrook Ave 21216</i> | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| FIRST MIDDLE LAST <i>William McClellan</i> | | | FIRST MIDDLE LAST <i>Daisy Brown</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | |
| <i>NO own</i> | | | <i>219-12-6928</i> | | | <i>Carrie McClellan 2814 Walbrook Ave</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Liver Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Metastatic tumor to liver</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Rectal carcinoma</i> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1/1/86</i> 19 <i>86</i> to <i>1/1/86</i> 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>1/1/86</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above. (I) (we) (did) (do) not view the body after death. | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | 22c. DATE SIGNED |
| <i>Thomas J. Walsh, MD</i> | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | <i>1/1/86</i> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | |
| <i>Thomas J. Walsh</i> | | | | | | <i>UMCC, 21201</i> | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| <i>Burial</i> | | | <i>1/7/86</i> | | <i>Baltimore Cemetery</i> | | <i>Balto. Maryland</i> | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | |
| <i>Charles A. Rice F.H.P.A. 1300 E. PL.</i> | | | | | | <i>JAN 3 1986 John K. ...</i> | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with page 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

620000

UNITED STATES DEPARTMENT OF AGRICULTURE

SEEDS OF THE WORLD

NC

009089

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01358

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) BETTY MCLUNG | | | 2a. DATE OF DEATH MONTH DAY YEAR JAN, 5, 1986 | | | 2b. HOUR A M 3:40 | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 30, 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS 71 | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager | | 12b. KIND OF BUSINESS OR INDUSTRY White Coffee | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 201 Washington St. 21231 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Custis Taylor | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Hopkins | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 223-18-6645 | | 17. INFORMANT ADDRESS Linda Funkhouser/219 N. Port St. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Massive hemoptysis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Lung cancer</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 minute</u> <u>2 minutes</u> <u>1 year</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>10</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>1/5</u> 19 <u>86</u> , to <u>1/5</u> 19 <u>86</u> , that (1) (we) last saw the deceased alive on <u>1/5</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Elaine C. Hefty</u> MD 22b. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Elaine C. Hefty, MD</u> | | | | | | DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <u>1/5/86</u> | |
| 22d. ADDRESS <u>600 N Wolfe St. Baltimore, MD</u> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1/9/86 | | 23c. NAME OF CEMETERY OR CREMATORY Wachapreague | | 23d. LOCATION CITY OR TOWN COUNTY Accomac Va. | | |
| 24. FUNERAL DIRECTOR NAME Lilly & Zeiler Inc. 1901 Eastern Ave | | | | | | 25a. DATE REC'D BY REGISTRAR JAN 7 1986 | | 25b. REGISTRAR'S SIGNATURE <u>John Davidson-Rodriguez</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be completed within 72 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be attached for use as the burial transit permit. Their place within the permit papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. IMPORTANT: If item 27 is marked as item 18 shows any injury or other significant event, the medical examiner must be notified at once.

BP

033023

PL 21 2011



STATE OF MARYLAND 8 6
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|---|---|---------------------------------|--|--|-----------------|-----------------------------------|------------------|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| JAMES Nathaniel McCOSH, Jr. | | | JAN. 18, 1986 | | | 8:05P M | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| Male | White | Dec. 2 1916 | 69 YRS. | | | MONTHS DAYS | | HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Minnesota | USA | | | BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | JOHNS HOPKINS HOSPITAL | | | Physician | | | Medical | |

| | | | | | |
|--|--|--------------------------|---|--------------------------------|--|
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE | |
| 13b. STATE 13c. CITY OR TOWN | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 8404 Bellona Lane, 21204 | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | |
| JAMES Nathaniel McCoch | | | Lucia Mundorf | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| Yes WW II | | 214-18-5355 | Mary A. McCosh, 8404 Bellona Lane, 21204 | | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> | | 15 min. |
| DUE TO, OR AS A CONSEQUENCE OF: (b) <u>chronic post operative course with CVA</u> | | 52 days |
| DUE TO, OR AS A CONSEQUENCE OF: (c) <u>Ischemic cardiac and cerebrovascular disease</u> | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO

| | | | |
|--|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| 11/27/85 | Coronary artery disease | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>19th Nov</u> 19 <u>85</u> to <u>18th Jan</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>18th Jan</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED | |
| <u>M. Sofroniew</u> | MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 18th Jan 1986 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS | | |
| M. Sofroniew | 800 N. WOLF ST. BALTO. MD. 21205 Johns Hopkins Hospital | | |

| | | | |
|--|-----------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
| Cremation | 1/21/86 | Westview Crematory | Catonsville Balto. Md. |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | |
| J. E. Lowell Lemmon, 10 W. Padonia Rd. | | JAN 22 1986 | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be secured with 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and filed in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the Medical Examiner must be notified and a necropsy performed.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) Vanessa A. McDaniels | | | 2a. DATE OF DEATH MONTH DAY YEAR 1/25/1986 | | 2b. HOUR 6:40 pm |
| 3. SEX F | 4. RACE B | 5. DATE OF BIRTH MONTH DAY YEAR 7 25 54 | | 6. AGE (IN YEARS LAST BIRTHDAY) 31 YRS | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) unknown | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | | | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST ALFRAED GAMBLE | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jacqueline Washington | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) unknown | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218603687 | 17. INFORMANT chart | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) adult respiratory distress syndrome DUE TO, OR AS A CONSEQUENCE OF (c) sepsis | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 h. 1 d. 5 d. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) severe malnutrition chronic severe pancreatitis | | | | | |
| 19a. DATE OF OPERATION N/A | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR N/A | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N/A | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/13/86 to 1/25/86, that (I) (we) last saw the deceased alive on 1/25/86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Matthew Wagner MD | | DEGREE MD | | 22c. DATE SIGNED 1/25/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Matthew Wagner | | 22e. ADDRESS Mercy Hospital Baltimore MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 1/30/86 | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE |
| 24. FUNERAL DIRECTOR FIRM NAME W. C. MARCH F/H INC. 1101 E. North Avenue | | 25a. DATE REC'D. BY REGISTRAR JAN 29 1986 | | 25b. REGISTRAR'S SIGNATURE Jana Duran | |

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

2008 Cotton 11556

INVESTMENT



JOHN R. SMITH

024025

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Aldo J. McDonald | | | 2a. DATE OF DEATH MONTH DAY YEAR 1/17/86 | | | 2b. HOUR 12:50 P.M. | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 5-24-08 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Baltimore, Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION St. Agnes Hospital | | | | 12a. USUAL OCCUPATION Auto Technician | | 12b. KIND OF BUSINESS OR INDUSTRY Auto Sales | |

| | | | | | | | | | | | | | | |
|---|--|--|--------------------------|--|--|---|--|--|---|--|--|--|--|--|
| 13a. STATE Md. | | | 13b. COUNTY Baltimore | | | 13c. CITY OR TOWN Catonsville | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE 722 Edmondson Avenue 21228 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Aldo --- McDonald | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jenny --- Martin | | | | | | | | |

| | | | | | |
|--|--|--|--|---|--|
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-01-5721 | | 17. INFORMANT 722 Edmondson Ave.-Catonsville Mrs. Margie A. McDonald-Md., 21228 | |
|--|--|--|--|---|--|

| | | | |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCHD (atherosclerotic heart disease)</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Meningitis</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
|---|--|---|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 20, 1985</u> to <u>Jan 17, 1986</u> , that (I) (we) last saw the deceased alive on <u>Jan 17, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Robert E. Dupree, Jr.</u> MD | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/17/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert E. Dupree, Jr. | | | | 22e. ADDRESS | | | |

| | | | | | | | |
|---|--|----------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/20/86 | | 23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery-Ellicott City, Md. | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Sterling Funeral Estate, P. A. 736 Edmondson Ave.-Catonsville, Md. 21228 | | | | 25a. DATE REC'D. BY REGISTRAR JAN 22 1986 | | 25b. REGISTRAR'S SIGNATURE <u>Julia Swickard-Randall</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file them in the file of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, state any injury, or other traumatic event, the medical

MEDICAL CERTIFICATION

024025

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Mr. Donald

2-24-68

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008010

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR **John Joseph McGarvey**

REG. NO.

| | | | | | | |
|---|--|--|--|---|----------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST John Joseph McGarvey | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 1 86 | | 2b. HOUR 9:20 PM | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 3 31 16 | | |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman | | 12b. KIND OF BUSINESS OR INDUSTRY Montgomery Ward | | 13a. STREET ADDRESS / ZIP CODE 7222 Fairbrook Road 21207 | | |
| 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Woodlawn | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frank McGarvey | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jenny McNicholas | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | |
| 16b. SOCIAL SECURITY NO. 218-03-4428 | | 17. INFORMANT Audrey McGarvey | | ADDRESS Same as # 13 | | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic disease - Terminal | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF (b) Adenocarcinoma of prostate | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-1-86 to 1-1-86 , that (I) (we) last saw the deceased alive on 1-1-86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Jose Fernandez M.D. | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1-1-86 | |
| 22d. PHYSICIAN'S HOME (TYPE OR PRINT) Jose Fernandez M.D. | | 22e. ADDRESS St. Agnes Hospital, Baltimore MD. | | | | | |

| | | | | | | | |
|---|--|----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/6/86 | | 23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Veterans | | 23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills Maryland | |
| 24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke | | | | 25a. DATE REC'D. BY REGISTRAR JAN 2 1986 | | 25b. REGISTRAR'S SIGNATURE John Davidson-Randall | |
| 1630 Edmondson Avenue, Catonsville, MD. 21228 | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

010200

010121

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD., 21201

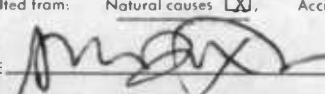
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PW 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01363

REG. NO.

| | | | | | | | | | | | | | | | | | | | | |
|--|--|------------------|----------------|--|--|---|--|---|---------------|--|--|---|--|-----------------------------------|---|--|--|--------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST JAMES | | | MIDDLE Lynn | | | LAST McGEE | | | 2a. DATE KNOWN OF DEATH ESTIMATED | | | <input checked="" type="checkbox"/> MONTH DAY 1 4 19 86 | | | 2b. HOUR M 6:22 PM | | |
| 3. SEX Male | | 4. RACE Negro | | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 4, 1918 | | 6. AGE (IN YEARS) LAST BIRTHDAY 67 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | | IF UNDER 24 HRS. HOURS MIN | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 4 19 86 | | | 2d. HOUR M 6:22 PM | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1626 E. 25th St. | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Steelworker | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| 13a. STATE Maryland | | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1626 East 25th Street | | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Lynne McGee | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie Higginbotham | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | | | 16b. SOCIAL SECURITY NO. WW II 066-01-8043 | | 17. INFORMANT ADDRESS 21213 Lucille McGee 1626 E. 25th St. | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | | | | | DATE SIGNED 1-5-86 | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | | ADDRESS 111 Penn St., Balto., MD 21201 | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 1-10-86 | | 23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEM. PK. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. CO MD | | | | | | | | | | |
| 24. FUNERAL DIRECTOR MARSHALL W JONES FR/4101 EDMONDSON AVE | | | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 8 1986 | | | | | | | | |

21213

MEDICAL CERTIFICATION



017059

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--|--|--|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Nelson Clearence McGrew | | | 2a. DATE OF DEATH MONTH DAY YEAR 11/6/86 | | | 2b. HOUR 122 AM | | | |
| 3 SEX male | | 4 RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR 06 09 13 | | 6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS | | IF UNDER 1 YEAR MONTHS DAYS 6 27 | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va USA | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10 CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Maryland Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Paint Foreman | | 12b. KIND OF BUSINESS OR INDUSTRY Steel Co. | |
| 13a STATE Maryland | | | 13b COUNTY Carroll | | 13c CITY OR TOWN Westminster | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Nathan McGrew | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Leasure | | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | |
| 16b SOCIAL SECURITY NO WW 2 | | | 17 INFORMANT Bonnie F. McGrew, Same As #13 | | | 17 ADDRESS 2356 Ellegrove Drive 21157 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/5</u> , 19 <u>86</u> , to <u>1/6</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>1/6</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Gordon M. Telepan</u> | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/6/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gordon M Telepan | | | 22e. ADDRESS 22 S. Greene St. Baltimore MD | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1-9-1986 | | 23c. NAME OF CEMETERY OR CREMATORY Lakeview Memorial | | 23d. LOCATION CITY OR TOWN COUNTY Eldersburg, Carroll, Md. | | |
| 24. FUNERAL DIRECTOR NAME Charles W. Burrier, Jr., Sykesville, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 10 1986 | | 25b. REGISTRAR'S SIGNATURE <u>Gordon M. Telepan</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 4 may be retained by the funeral director. Pages 1 and 2 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the death certificate should be retained at the hospital or attending physician's office.

01-1159

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

01365

| | | | | | | | | | |
|---|--|--|--|---|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Margaret T. Mc Guire | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 6 1986 | | | 7b. HOUR M | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 10 14 1892 | | 6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS | | 7a. IF UNDER 1 YEAR MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ireland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Jennings Home 1000 S. Caton Ave. 21229 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 1211 St Andrews Way 21239 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Thomas Keaveney | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Murray | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | |
| 16b. SOCIAL SECURITY NO. 214 74 2281 | | | | 17. INFORMANT ADDRESS Francis J. McGuire 1211 St. Andrews Way Balto Md 21239 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } <u>Arteriosclerotic cardiovascular disease</u> years DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1-6-86</u> to <u>1-6-86</u> , that (I) (we) lost <u>say</u> the deceased alive on <u>1-6-86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (not) view the body after death. | | | | | | | | | |
| 22a. SIGNATURE <u>Lawrence R. Gallagher MD</u> | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>1-7-86</u> | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Lawrence Gallagher | | | | | 22e. ADDRESS 3455 Wilkens Ave. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1/9/1986 | | 23c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Long Green Balt Md. | | |
| 24. FUNERAL DIRECTOR NAME Geo. J. Gonce F.H. 4001 Ritchie Hwy 21225 | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

034017

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

0 1 3 6 6

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|---|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) ALEXANDER E. McILMAIL | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 27, 1986 | | | 2b. HOUR 3:55 A M | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR August 9, 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ireland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | | |
| 10. CITY OR TOWN OF DEATH Cockeysville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Maryland Masonic Homes | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Conductor | | 12b. KIND OF BUSINESS OR INDUSTRY Railroad | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | 13b. CITY OR TOWN Harford | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE 305 Garner Rd. 21085 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Jame McIlmail | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helena Watterson | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 705-10-4672 | | 17. INFORMANT ADDRESS Helena A. Williams Same | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Lung Cancer DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Heart Failure | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I/we died, did not view the body after death.) | | | | | | | | | |
| 22b. SIGNATURE Paul Rivas | | | | DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 1-28-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul Rivas, M.D. | | | | 22e. ADDRESS Maryland Masonic Homes, Cockeysville, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE Jan. 30, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Parkville, Balto. Co., Md. | | |
| 24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home, Inc. | | | | ADDRESS 6500 York Rd. 21212 | | 25a. DATE REC'D. BY REGISTRAR JAN 30 1986 | | 25b. REGISTRAR'S SIGNATURE Elia Rivas-Rodriguez | |

MEDICAL CERTIFICATION

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BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

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CHIEF OF POLICE



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

01367

FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|--|--|---|--------------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) LUCY J. MCLAWHORN | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 28, 1986 | | 2b. HOUR MIN. 5:00 A | | |
| 3. SEX Female | | 4. RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR 9 13 1902 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) YRS. 83 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Comfort Manu. Co. | | 12b. KIND OF BUSINESS OR INDUSTRY Sewing | |
| 13a. STATE Md. | | 13b. COUNTY Balto. | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE 717 N. Payson 21217 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles Albrighton | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susie Barrett | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 239-01-6745 | |
| 17. INFORMANT ADDRESS Charlie McLawhorn 4042 Cedardale Rd. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Overwhelming pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Aspiration | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 mins 1 wk | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Renal failure, sepsis 2° to decubitus ulcers, UTI | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from January 10, 1986 , to January 28, 1986 , that (I) (we) last saw the deceased alive on January 28, 1986 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death. | | | | | | | |
| 22b. SIGNATURE SR Jones, MD | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/28/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SR JONES, MD | | 22e. ADDRESS JOHNS HOPKINS HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 2/2/86 | | 23c. NAME OF CEMETERY OR CREMATORY Sunset Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Farmville, N.C. | |
| 24. FUNERAL DIRECTOR NAME JAS. A. MORTON & SONS | | ADDRESS 1701 Laurens | | 25a. DATE REC'D. BY REGISTRAR IAN 29 1986 | | 25b. REGISTRAR'S SIGNATURE | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpaper tag. Label 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

93917 NOTED 8:00

UNDER MATH-73/H



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020264

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|--|---|---|---|--|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) George A. McNULTY | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 / 12 / 86 | | | 2b. HOUR 6:37 PM | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 6 / 25 / 23 | | 6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) P.A. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Med Ctr | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STEEL WORKER | | 12b. KIND OF BUSINESS OR INDUSTRY STEEL | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN FORT HOWARD | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 7508 Blank Ave. 21052 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frank McNULTY | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mae Stiffler | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes WW II | | | 16b. SOCIAL SECURITY NO. 176-16-1989 | | 17. INFORMANT ADDRESS CAROLINE McNULTY. | | | | Same as 13e | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arrhythmia. DUE TO, OR AS A CONSEQUENCE OF (c) MI | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CHF, COPD. | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) HOME | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/12 , 19 86 , to 1/12 , 19 86 , that (I) (we) last saw the deceased alive on 6:37 1/12 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) did not view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE James J. Callum M.D. DEGREE B. Rothschild M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | 22c. DATE SIGNED 1/12/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) B Rothschild MD | | | | | | 22e. ADDRESS Francis Scott Key Med Ctr | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1/15/1986 | | 23c. NAME OF CEMETERY OR CREMATORY Louden Park | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | |
| 24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 16 1986 | | 25b. REGISTRAR'S SIGNATURE J. H. Davidson | | |
| 7922 Wise Avenue Dundalk, Maryland 21222 | | | | | | | | | | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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07/84
25MBP
DHMH - 17
(VR A15 ME (5))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. IF THE DEATH IS SUSPECTED TO BE A BURIAL - TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 01369 | |
|---|--|--|--|--|--|--|--|--|--|---|--|
| 1- STATE REGISTRAR | | | | | | | | | | 2a. DATE KNOWN OF DEATH | |
| 1. DECEASED NAME FIRST MIDDLE LAST PAUL MILTON McQUEEN | | | | | | | | | | 2b. DATE KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> 1-27-86 19 | |
| 2. SEX 3. RACE 4. DATE OF BIRTH MONTH DAY YEAR 5. AGE (IN YEARS LAST BIRTHDAY) 6. IF UNDER 1 YR. MONTHS DAYS 7. IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | | 2d. DATE PRONOUNCED DEAD 1-27-86 19 4:34 PM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) 7b. CITIZEN OF WHAT COUNTRY? 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Maryland U.S.A. | | | | | | | | | | Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore 1302 Pennsylvania Avenue | | | | | | | | | | Unemployee | |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS | | | | | | | | | | 21217 1302 Pennsylvania Ave. Apt. 2B | |
| 14. FATHER'S NAME FIRST MIDDLE LAST 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | | | | |
| Rudolph McQueen Brightsy Kyser | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) 16b. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS | | | | | | | | | | Apt. L5 | |
| NO 218-80-0871 RUDolph McQueen 3320 Presstman Street | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of chest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY MONTH DAY YEAR 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 4:25 PM 1-27-86 subject shot | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| rear courtyard 1302 Pennsylvania Avenue Baltimore, Md. | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Margareta McQueen</u> M.D. Assistant MEDICAL EXAMINER DATE SIGNED 1-28-86 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn Street | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| BURIAL 2/1/86 Mount Auburn Cemetery Baltimore, Md. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| March Funeral H0mes 1101 East North Avenue JAN 31 1986 <u>Margareta McQueen</u> | | | | | | | | | | | |

1950

DEBBY MORTON

PITTSBURGH, PA.

1950

035118

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) EMMA JANE Mellor | | 2a. DATE OF DEATH MONTH DAY YEAR 1-29-86 | | 2b. HOUR 0055 M. | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR July 26, 1902 | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS. | | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Cnty, Md. | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary - Construction | |

| | | | | | |
|---|--|---|--|---|--|
| 13a. STATE Md. | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Catonsville | |
| 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 109 S. Hilltop Road 21228. | | | |

| | | | |
|---|--|--|--|
| 14. FATHER'S NAME FIRST MIDDLE LAST Albert J. Mellor | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura M. Hogan | |
|---|--|--|--|

| | | | | | |
|---|--|--|--|--|--|
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 212-03-8785 | | 17. INFORMANT ADDRESS Catonsville, Md. 21228 James P. Collins, Jr. - 103 S. Hilltop | |
|---|--|--|--|--|--|

| | | | |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) prob MI DUE TO, OR AS A CONSEQUENCE OF (c) sepsis | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 min 24 hrs. 3 days. | |
|--|--|---|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | | | |
|--|--|--|--|--|--|
| 19a. DATE OF OPERATION 1/4/86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED paracolostomy hernia repair | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |

22a. I certify that (I) (this hospital) attended the deceased from **1/21/86** to **1/29/86**, that (we) lost (saw the deceased) alive on **1/29/86** and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) did (did not) view the body after death.

| | | | | | |
|--|--|---------------------------------------|--|------------------------------------|--|
| 22b. SIGNATURE Rodney H. Lahren MD | | DEGREE MD | | 22c. DATE SIGNED 1/29/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rodney H. Lahren | | 22e. ADDRESS 900 Caton Ave. | | | |

| | | | | | |
|---|--|----------------------------|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 2/1/86 | | 23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery - Ellicott City, Md. | |
|---|--|----------------------------|--|---|--|

| | | | | | |
|---|--|---|--|---|--|
| 24. FUNERAL DIRECTOR NAME Sterling Funeral Estate, P. A. | | 25a. DATE REC'D. BY REGISTRAR JAN 31 1986 | | 25b. REGISTRAR'S SIGNATURE Galia Davidson-Randall | |
|---|--|---|--|---|--|

23d. LOCATION
CITY OR TOWN COUNTY STATE
236 Edmondson Ave. Catonsville, Md. 21228

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and legally filed with the funeral director, page 3 should be detached for use on the burial/transit permit. There please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|--|--|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) ROBERT W. MENS | | | 2a. DATE OF DEATH MONTH DAY YEAR 1/2/86 | | | 2b. HOUR 12:24 P.M. | | | |
| 3. SEX M | | 4. RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR 8 24 35 | | 6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 50 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH City MD. | | | |
| 10. CITY OR TOWN OF DEATH Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) U. of Md. Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled | | 12b. KIND OF BUSINESS OR INDUSTRY Holloway + Company | |
| 13a. STATE MD | | 13b. COUNTY — | | 13c. CITY OR TOWN BALTO | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 5506 Lynview Ave 21215 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Randall Mens | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT ADDRESS Kim Mens 5506 Lynview Ave | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) BRAINSTEM STROKE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min. 14 days | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a) AODM, HTN. | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 1/2/86 to 1/2/86 , that (1) (we) last saw the deceased alive on 1/2/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Sharon D. Bisco MD. | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/2/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sharon D. Bisco, MD | | | 22e. ADDRESS U. of Md. Hosp. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1/6/86 | | 23c. NAME OF CEMETERY OR CREMATORY King Memorial Park | | 23d. LOCATION CITY OR TOWN COUNTY Randallstown MD | | |
| 24. FUNERAL DIRECTOR NAME William C. March F/H West 4300 Wabash Avenue | | | | | | 25a. DAY BY REC'D BY JAN 11 1986 | | 25b. REGISTRAR'S SIGNATURE | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the funeral home permit. Then please remove the pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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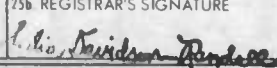
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01372

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|------------------|---|---|---|---------------------------------------|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Elizabeth Merritt | | | | 2a. DATE KNOWN OF DEATH ESTIMATED XX 1 15 1986 | | | | 2b. HOUR M | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 5 12 15 | 6. AGE (IN YEARS) (LAST BIRTHDAY) 70 YRS. | 7. IF UNDER 24 YRS. MONTHS DAYS HOURS MIN | 2c. DATE PRONOUNCED DEAD 1 15 1986 | | 2d. HOUR 3:35P M | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Connecticut | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1503 Pentridge Road | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Office | | 12b. KIND OF BUSINESS OR INDUSTRY College | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | | 13b. COUNTY | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | 13e. STREET ADDRESS 1503 Pentridge 21239 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Unkn. | | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. 047-07-8571 | | 17. INFORMANT Ms. Catherine Fry | | ADDRESS 3729 Bonview Ave. Balto., Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Breast cancer | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE  | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 1/21/86 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | ADDRESS 111 Penn St. Balto. MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b. DATE 1/15/86 | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| 24. FUNERAL DIRECTOR NAME Anatomy Board | | | | ADDRESS Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR JAN 28 1986 | | 25b. REGISTRAR'S SIGNATURE  | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL. ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR: PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4
25M

BP

DHMH - 17
(VR A15 ME (5))

COOLING TOWER

WATER TOWER



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|--|---|--|--|---|---|--|--|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) KATHERINE G. MEYERS | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 21 86 | | | 2b. HOUR 4:15 M | | | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 9 XXX 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY) 84 XXX 83 YRS | | 7. UNDER 1 YEAR MONTHS DAYS | | 8. UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (COUNTRY) BALTIMORE | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LEVINDALE | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY | | 12b. KIND OF BUSINESS OR INDUSTRY CLERICAL | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 301 McMECHEN ST. #21217 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ABRAHAM MEYERS | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LENA KLAWSKY | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-12-8959 | | 17. INFORMANT ALVIN SUSKIN BOX 101 ROCK HALL, MD 21661 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) OBSTRUCTIVE PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (c) ACUTE MYOCARDIAL INFARCTION | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 DAY 1 DAY 1 DAY | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-3 , 19 84 , to 1-21 , 19 86 , that (I) (we) last saw the deceased alive on 1-21 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE AJLwco | | | | DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 1-21-86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) AJLwco | | | | 22e. ADDRESS 2434 W BELLEVUE AVE BALTO MD 21215 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE JAN. 22, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY CHIZUK AMUNO | | | 23d. LOCATION BALTIMORE COUNTY MARYLAND | | | |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 24 1986 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

MEDICAL CERTIFICATION

210 18 12

STATION

STATION



022039

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|--|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HILDA MICHAL | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 18 86 | | | 2b. HOUR 1239A | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 11 17 20 | | 6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assemblyline | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY Maryland A.A. | | | | 13c. CITY OR TOWN Glen Burnie | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Edward Merson | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Englemann | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 217-16-3819 | | 17. INFORMANT ADDRESS William C. Michal, R.R.#1, Box 185 A Marydel Md., 21649 | | | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/17 19 86 to 1/18 19 86 , that (I) (we) last saw the deceased alive on 1/18 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE John Sitavias | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/18/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OFFICE) | | | | 22e. ADDRESS 10 NORTH DAYSON ST BALT. MD 21223 | | | |

| | | | | | | | |
|--|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/20/86 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Hubbard Funeral Home, INC., 4107 Wilkens Ave. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 20 1986 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please attach it to the death certificate. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

035023

REC-1

U.S. GOVERNMENT PRINTING OFFICE

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 1 3 7 5

017107

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|-------------------------|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Herman Middleton | | 2a. DATE OF DEATH MONTH DAY YEAR January 10, 1986 | | 2b. HOUR 1:25 PM | |
| 3. SEX MALE | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR Mar. 12, 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) South Carolina | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) American Stand. | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. STREET ADDRESS / ZIP CODE 541 W. Lafayette Avenue 21217 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Sam Middleton | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dolly Loyal | | | |

| | | | | | |
|--|--|--|--|---|--|
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | 16b. SOCIAL SECURITY NO. WW II 217-09-8824 | | 17. INFORMANT ADDRESS Esther Middleton 21217 541 W. Lafayette Ave. | |
|--|--|--|--|---|--|

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis and acute respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) Extensive bilateral pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a)

Brain stem stroke

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |

22a. I certify that (he/she) attended the deceased from **January 8, 1986** to **January 10, 1986**, that (X) (we) lost
saw the deceased alive on **January 10, 1986**, and that in (our) opinion death occurred on the date and hour and from the causes stated
above X (we) (did) view the body after death.

| | | | | | | | |
|---|--|--|--|--|--|------------------------------------|--|
| 22b. SIGNATURE Clarence Edwin Beckett Jr. M.D. | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/10/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Clarence Edwin Beckett Jr. M.D. | | 22e. ADDRESS c/o Maryland General Hospital | | | | | |

| | | | | | | | |
|---|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/15/86 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem. | | 23d. LOCATION Baltimore, Maryland STATE | |
|---|--|-----------------------------|--|--|--|---|--|

| | | | | | | | |
|---|--|-----------------------------|--|---|--|--|--|
| 24. FUNERAL DIRECTOR Leroy O. Dyett | | ADDRESS 4600 L... | | 25a. DATE REC'D. BY REGISTRAR JAN 14 1986 | | 25b. REGISTRAR'S SIGNATURE Jeha Davidson-Randall | |
|---|--|-----------------------------|--|---|--|--|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, the certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be filed at once.

035073

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|--|--|---|---|---|---|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HANNAH JOAN MILD | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 28, 1986 | | 2b. HOUR 0:20P M | | | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR APRIL 3, 1937 | | 6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GERMANY | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) teacher asst. | | 12b. KIND OF BUSINESS OR INDUSTRY optometry | | |
| 13a. STATE Md. | | | 13b. COUNTY A.A.Co. | | 13c. CITY OR TOWN Edgewater | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 3269 Wendlyn Way 21037 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Sigmund Forsch | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Herta Siedenberg | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- 267-48-7158 | | 17. INFORMANT ADDRESS Lawrence M. Mild same as 13e. | | | | | |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) REFRACTORY HYPOTENSION

DUE TO, OR AS A CONSEQUENCE OF

(b) SEPSIS

DUE TO, OR AS A CONSEQUENCE OF

(c) ACUTE MYELOGENOUS LEUKEMIA

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

24 HOURS

3 DAYS

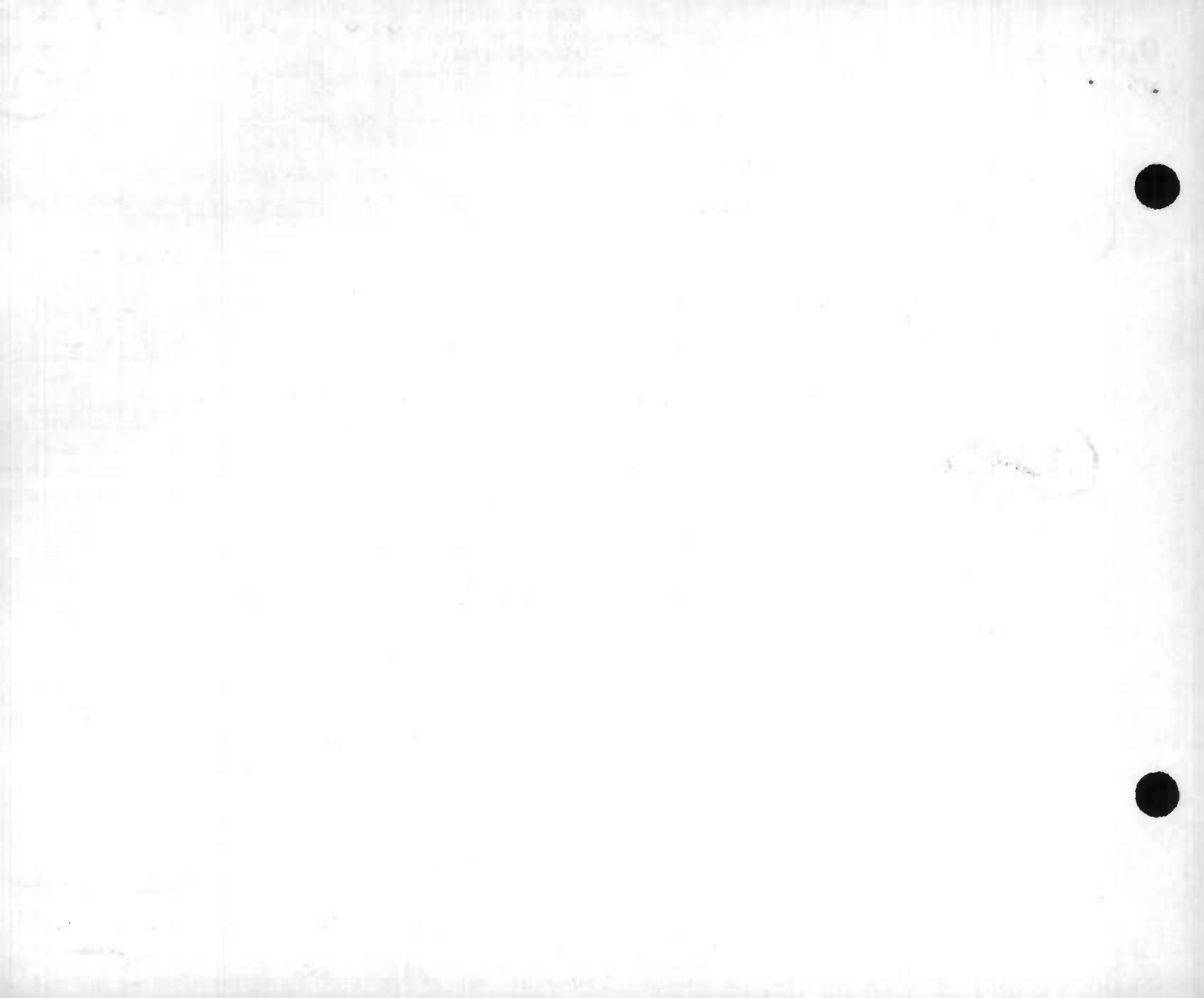
21 MONTHS

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:

RADIOTHERAPY FOR OVARIAN CARCINOMA IN 1980

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from DEC 7, 1985, to JAN 28, 1986, that (I) (we) last saw the deceased alive on JAN 28, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Mark Kozak MD | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/28/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARK KOZAK, M.D. | | | | 22e. ADDRESS JHH 600 N. WOLFE ST. BALTO., MD. 21205 | | | |

| | | | | | | | |
|--|--|----------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/31/86 | | 23c. NAME OF CEMETERY OR CREMATORY Kneseth Israel | | 23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A.Co. Md. | |
| 24. FUNERAL DIRECTOR NAME Hardesty Funeral Home | | | | 12 Ridgely Ave. ADDRESS Annapolis, Md. 21401 | | 25a. DATE REC'D. BY REGISTRAR JAN 31 1986 | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME

(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Catherine Miller

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

1 30 86

6 32 AM

3. SEX

Female

4. RACE

White

5. DATE OF BIRTH

MONTH

DAY

YEAR

11 02 95

6. AGE (IN YEARS LAST BIRTHDAY)

70

IF UNDER 1 YEAR

IF UNDER 24 HRS.

MONTHS

DAYS

HOURS

MIN.

7a. BIRTHPLACE

(STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

Francis Scott Key Medical Center

12a. USUAL OCCUPATION

Retired

12b. KIND OF BUSINESS OR INDUSTRY

Housework

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

Maryland

13b. COUNTY

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

810 South Dear Street 21224

14. FATHER'S NAME

FIRST

MIDDLE

LAST

Nau

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)

17. INFORMANT

212-16-43920

18. ADDRESS

Robert L. Parrish 810 S. Dear St. 21224

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Aspiration Pneumonia, cardiopulm. Arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Acute Renal Failure, Pneumonia, Heart Failure

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/21, 19 86, to 1/30, 19 86, that (I) (we) lost

saw the deceased alive on 1/30, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

Mark Eisner MD

DEGREE

ATTENDING PHYSICIAN ☐MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☒

22c. DATE SIGNED

1/30/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

MARK EISNER MD

22e. ADDRESS

4940 EASTERN AVE Balt MD

23a. BURIAL, CREMATION, REMOVAL

(SPECIFY)

Burial

23b. DATE

2-1-86

23c. NAME OF CEMETERY OR CREMATORY

Sacred Heart of Jesus

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

Dundalk, Balto. Co., Md.

24. FUNERAL DIRECTOR

Charles S. Zeiler & Son Inc. 901 S. Conkling St

25a. DATE REC'D. BY REGISTRAR

FEB 03 1986

25b. REGISTRAR'S SIGNATURE

James W. H. H. H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

0 1 3 7 8

1. FOR
STATE
REGISTRAR

REG NO

| | | | | | |
|---|--------------|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) CURTIS L. Miller | | 2a. DATE OF DEATH MONTH DAY YEAR 1 14 86 | | 2b. HOUR 7 35 AM | |
| 3. SEX M | 4. RACE B | 5. DATE OF BIRTH MONTH DAY YEAR 10 7 38 | | 6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) S.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH City | | 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deacon Hospital & Medical Center | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | 12c. BALTIMORE CITY OR COUNTY OF DEATH MD | |
| 13a. STATE Md. | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Louis Miller | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie Miller | | 16. STREET ADDRESS / ZIP CODE 540 S. Paca St 21230 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. 216-34-2554 | | 17. INFORMANT Lillie Miller | |
| 18. CAUSE OF DEATH (Enter only one cause per item for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Sepsis & respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) S/P Cardiovascular arrest & come Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Diabetes mellitus | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 21a. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21b. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2) | |
| 21c. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21e. LOCATION CITY OR TOWN COUNTY STATE | |
| 22. I certify that (1) (this hospital) attended the deceased from 12 Nov 85 to 14 Jan 86, that (1) (we) last saw the deceased alive on 14 Jan 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (and) (did not) view the body after death. | | | | | |
| 22a. SIGNATURE J. W. REED M.D. | | DEGREE | | 22b. DATE SIGNED 1/14/86 | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT) J. W. REED | | 22d. ADDRESS 611 S. CHAS. ST. BALTO MD 21230 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/20/86 | | 23c. NAME OF CEMETERY OR CREMATORY Md. Veteran Cem. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville A.A. Md. | | 24. FUNERAL DIRECTOR NAME Chas. A. Rice FSPA 1300 | | 25. DATE REC'D. BY REGISTRAR JAN 29 1986 | |
| 25b. REGISTRAR'S SIGNATURE | | | | | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of page 2 and file it within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the attending physician must be notified of any

028171

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|--|--|--|---|--|---|---|--|---|-------|--|
| 1 DECEASED NAME (TYPE OR PRINT) GERALD T MILLER | | | 2a DATE OF DEATH MONTH DAY YEAR 1-18-86 | | | 2b HOUR 3:55 PM | | | | |
| 3 SEX Male | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR June 17 1935 | | 6 AGE (IN YEARS LAST BIRTHDAY) 50 | | 7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Franklin, Pa. | | 7b CITIZEN OF WHAT COUNTRY? U, S. A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | |
| 10 CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hos. Baltimore, Md. | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Printer | | 12b KIND OF BUSINESS OR INDUSTRY Paumier Press | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland | | | 13b COUNTY Harford | | 13c CITY OR TOWN Edgewood | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Charles Miller | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hazel McQuaid | | | 16 ADDRESS 1920 Chipper Drive | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes | | | 16b SOCIAL SECURITY NO. 220-30-1714 | | 17 INFORMANT Mrs. Marjorie A. Miller, Edgewood, Md. | | | | 21040 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive pulmonary hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) Squamous cell lung cancer DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 minutes | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 1/17 to 1/18 1986, that (I) (we) lost saw the deceased alive on 1/18 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b SIGNATURE Evan J. Selsky MD | | | DEGREE MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c DATE SIGNED 1/18/86 | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Evan J. Selsky MD | | | 22e ADDRESS Mercy Hospital 301 St. Paul Place Balt. Md 21202 | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b DATE 1-21-1986 | | 23c NAME OF CEMETERY OR CREMATORY St. Mary's Episc. Ch.Cem. | | 23d LOCATION CITY OR TOWN COUNTY STATE Abingdon Harford Md. | | | | |
| 24 FUNERAL DIRECTOR NAME E. F. Lassah, 11750 Belair Rd. Kingsville, Md. 21081 | | | | | 25a DATE REC'D. BY REGISTRAR JAN 23 1986 | | 25b REGISTRAR'S SIGNATURE John H. ... | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other troubling condition, the medical examiner will be notified at once.

036011

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

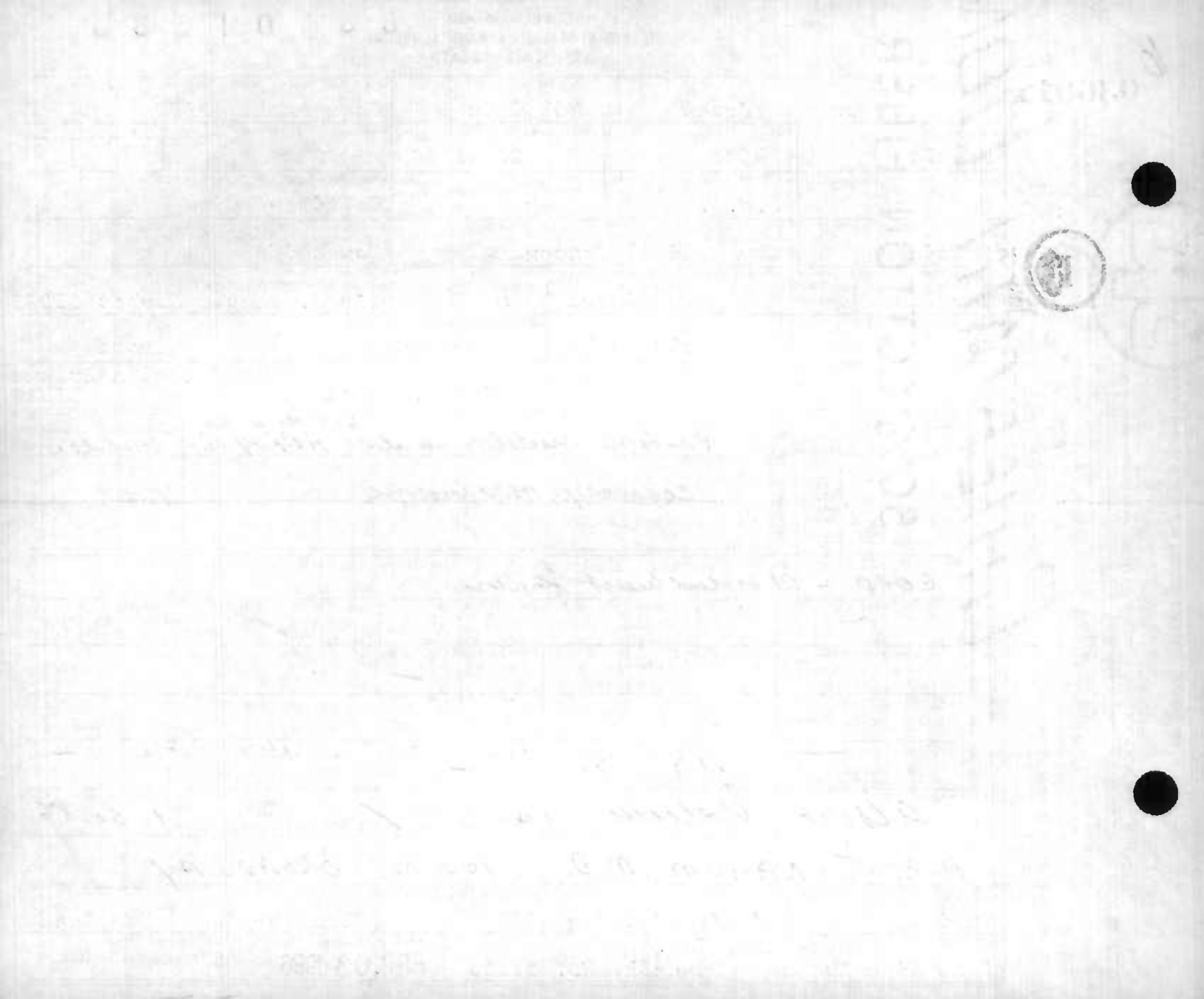
| | | | | | | | | | | |
|--|--|--|--|---|---------------------------------------|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Anna Joann Millikin</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>January 28, 1986</i> | | | 2b. HOUR M <i>M</i> | | | | |
| 3. SEX <i>Female</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>7 15 1916</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS <i>69</i> | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <i>IF UNDER 24 HRS.</i> | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD. | | | | |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Key Medical Center</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <i>Maryland</i> | | | 13b. COUNTY | | 13c. CITY OR TOWN <i>Baltimore</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE <i>210 S. Castle Street 21231</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>John Soltyivsky</i> | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Maryanna Drozd</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>213-14-8988</i> | | 17. INFORMANT <i>Elaine J. Eckstein</i> | | ADDRESS <i>865 Loalan Avenue</i> | | ZIP CODE <i>21222</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Probable sudden cardiac Arrhythmia</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Coronary Artery Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>years.</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden.</i> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>COPD - Rt sided heart failure.</i> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <i>1/18</i> , 19 <i>86</i> , to <i>1/19</i> , 19 <i>86</i> , that (I) (we) saw the deceased alive on <i>1/19</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <i>Albert Nahum</i> | | DEGREE <i>M.D.</i> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <i>1. 30. 86</i> | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ALBERT NAHUM, M.D.</i> | | | | 22e. ADDRESS <i>100 N. BROADWAY</i> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>1/31/1986</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Glen Burnie Maryland</i> | | | | |
| 24. FUNERAL DIRECTOR NAME <i>Duda-Ruck, Inc.</i> ADDRESS <i>7922 Wise Avenue Dundalk, MD. 21222</i> | | | | 25a. DATE REC'D. BY REGISTRAR <i>FEB 03 1986</i> | | 25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | | |

BP.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be retained for 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.



038132

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 1 3 8 1

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) CLAIRE D. MINKINOW | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 30, 1986 | | | 2b. HOUR 3:45P M | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 12-27-1914 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Realtor | | 12b. KIND OF BUSINESS OR INDUSTRY Real Estate | |
| 13a. STATE Md. | | 13b. COUNTY aaco | | 13c. CITY OR TOWN Annapolis | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 130 Hearne Rd. 21502 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Johann Hammer | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Oehme | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-40-6027 | | 17. INFORMANT ADDRESS Annapolis, Md. Irene Fink 394 Blossom Ter. Dr. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of the lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>1 1/2 years</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Renal failure; atelectasis</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>1/16/86</u> , 19 <u>86</u> , to <u>1/30</u> , 19 <u>86</u> , that (2) (we) last saw the deceased alive on <u>1/30</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>R. Brian Mitchell</u> | | | | DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED <u>1/30/86</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. Brian Mitchell | | | | 22e. ADDRESS 601 N. Wolfest. Balt. MD 21218 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 2-2-86 | | 23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis, AAcco. Md. | | | |
| 24. FUNERAL DIRECTOR NAME Hardesty Funeral Home | | | | ADDRESS Annapolis, Md. | | 25a. DATE REC'D. BY REGISTRAR FEB 05 1986 | | 25b. REGISTRAR'S SIGNATURE <u>Juha Davidson-Hendell</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be received within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transmittal form. Then please attach the detached page 3 to the back of the certificate. The certificate should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

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Levin, Joseph - 112

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Nathaniel E Minter | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 24 86 | | | 2b. HOUR 1 A.M. | | | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 7 02 1933 | | 6. AGE (IN YEARS LAST BIRTHDAY) 52 | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 9. CITIZEN OF WHAT COUNTRY? U. S. A. | | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 12. CITY OR TOWN OF DEATH Baltimore | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) V A Hospital Loch Raven | | | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | | 15. KIND OF BUSINESS OR INDUSTRY Beth. Steel | |

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 3a. STATE Maryland | | 17. COUNTY Baltimore | | 18. CITY OR TOWN Baltimore | | 19. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20. STREET ADDRESS / ZIP CODE 1805 Penrose Ave. Baltimore, Maryland 21223 | |
| 21. FATHER'S NAME FIRST MIDDLE LAST Edward Minter | | | | 22. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Reva Burris | | | | | |
| 23. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 24. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korean | | 25. INFORMANT 1411 Thigpesside Avenue Rosa Cauthorne Baltimore, Maryland 21207 | | | | | |

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Adeno Carcinoma of the Lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>22 mos.</u> | | | | | | | |
|--|--|--|--|--|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |

22a. I certify that (I) (this hospital) attended the deceased from 1/23, 1986, to 1/24, 1986, that (I) (we) lost
saw the deceased alive on 1/24, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

| | | | | | |
|--|--|--|--|-----------------------------|--|
| 22b. SIGNATURE Valerie J. Barnwell | | DEGREE MD | | 22c. DATE SIGNED 1/24/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Valerie J. Barnwell | | 22e. ADDRESS 3900 Loch Raven Blvd. Baltimore Md 21218 | | | |

| | | | | | | | |
|--|--|------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/29/1986 | | 23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Veteran | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | |
|--|--|------------------------|--|---|--|---|--|

| | | | | | |
|---|--|--|--|---|--|
| 24. FUNERAL DIRECTOR (NAME) Nelson & Sons Funeral Home, Inc. 2501 Gwynn's Falls Pkwy. Baltimore, Md. 21216 | | 25a. DATE REC'D. BY REGISTRAR FEB 03 1986 | | 25b. REGISTRAR'S SIGNATURE John Davidson | |
|---|--|--|--|---|--|

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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Source: 0157
A. 0157-0157-0157
0157-0157-0157

MADE IN THE U.S.A.

20% COTTON YARN

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MILK FARM



**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH**

8 6 0 1 3 8 4

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) Nora B. Minter | | | 2a. DATE OF DEATH MONTH DAY YEAR January 28, 1986 | | 2b. HOUR 12:29A |
| 3. SEX Female | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 7 20 10 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 924 Newington Avenue 21217 |
| 14. FATHER'S NAME FIRST MIDDLE LAST Willie Morrison | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cowan | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unknown | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-20-9234 | 17. INFORMANT ADDRESS Yvonne Bundley 924 Newington Avenue | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Dysrhythmia DUE TO, OR AS A CONSEQUENCE OF (b) Probable Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Acidosis | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Hyperglycemia, Renal Failure, Severe Peripheral Vascular Disease | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from November 29, 1985 to January 28, 1986 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on January 28, 1986 , and that in <input checked="" type="checkbox"/> (my) opinion death occurred on the date and hour, and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death. | | | | | |
| 22b. SIGNATURE Thomas Ganey | | DEGREE MD | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/28/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas Ganey, M.D. | | 22e. ADDRESS c/o Maryland General Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE 2/3/86 | 23c. NAME OF CEMETERY OR CREMATORY King Memorial Park | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore County, Md. | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS March Funeral Homes 1101 East North Avenue | | | 25a. DATE REC'D. BY REGISTRAR JAN 31 1986 | 25b. REGISTRAR'S SIGNATURE [Signature] | |

MEDICAL CERTIFICATION

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035108

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, 4, AND 5 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PENDING PERMIT. PAGES 1, 2, 3, 4, AND 5 SHOULD BE FILED, WITHIN 72 HOURS, TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1, 2, 3, 4, AND 5 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP _____
DHMH - 17
(VR A15 ME (5))1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

01385

| | | | | | | | | | | | | | | | | | |
|--|---------|--|--|--|--|---|--|-------------------------|--|---|--|-------|--|------|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | <input checked="" type="checkbox"/> MONTH | | DAY | | YEAR | | 2b. HOUR | |
| Clara | | W. | | Minthorn | | | | 1-12 | | 19 | | 86 | | | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | |
| F | B | 11 18 1922 | | 63 YRS. | | | | | | 1-12 | | 19 | | 86 | | P. M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| Va. | | U.S.A. | | | | Baltimore City, | | | | | | | | | | MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Baltimore | | Maryland General Hospital | | Clerk | | Hotel | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | |
| Md. | | | | Balto | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 709 Newington Ave. | | | | | | | | 21217 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| Charlie | | Walker | | Mary | | Carter | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| No | | | | Mrs. Gail Godwin | | 709 Newington Ave. | | | | | | | | | | 21217 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | | | | | | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | FILE (SPECIFY) | | M.D. Assistant | | MEDICAL EXAMINER | | DATE SIGNED 1-13-86 | | | | | | | | | |
| ACTUAL SIGNATURE | | EXAMINER'S NAME (TYPE OR PRINT) | | Dennis F. Smyth, M.D. | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| Burial | | 1-14-86 | | Westview Cemetery | | Balto. Md. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| Jas A. Morton & Sons | | 1701 Laurens | | JAN 14 1986 | | | | | | | | | | | | | |

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20% COTTON FIBER

MADE IN AFRICA



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|---|---|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST HERBERT | MIDDLE MITCHELL | LAST MITCHELL | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 16, 1986 | 2b. HOUR 10:15pm M |
| 3. SEX Male | 4. RACE Negro | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 3, 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Custodian | 12b. KIND OF BUSINESS OR INDUSTRY Retired | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 1209 Ashland Avenue 21202 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Mitchell | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosina Hardin | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | |
| 16b. SOCIAL SECURITY NO. 218-03-9458 | | 17. INFORMANT ADDRESS Rosina M. Crawford 1209 Ashland Ave. 21202 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 minutes |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>recent myocardial infarction, renal failure, hx of colon cancer</u> | | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/10/86</u> 19 <u>86</u> to <u>1/16/86</u> 19 <u>86</u> , that (I/we) last saw the deceased alive on <u>1/16/86</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE <i>Wolfe</i> | | DEGREE | | | 22c. DATE SIGNED 1/17/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Matthew R. Wolfe | | 22e. ADDRESS 600 N WOLFE ST BALTO MD 21205 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 1-23-86 | 23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Marshall W. Jones FH/4101 Edmondson Ave. 21229 | | | | 25a. DATE REC'D. BY REGISTRAR JAN 20 1986 | 25b. REGISTRAR'S SIGNATURE <i>John Davidson-Pond</i> | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician, it must be completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then place this certificate in the "Certificate of Death" folder of the funeral papers.

TO THE STATE DEPT. OF HEALTH AND MENTAL HYGIENE: This certificate must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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Male
Maryland

West
MD

Feb. 3, 1903
X

22

Gratford
Berlin

100 Ashland Avenue
2102

Baltimore
X

Maryland

Mitchell
Poston
Berlin

218-03-45
Poston M. Crawford 100 Ashland Ave. 2102



RECEIVED
JAN 10 1903
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

Baltimore City, Maryland

Baltimore Cemetery

1-23-03

Marial

Marshall W. Jones 101 Edmondson Ave. 2122

027091

 1- FOR *Item 18a-22a*
 STATE REGISTRAR *3-18-86 CN*

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01381

REG. NO.

| | | | | | | | | | |
|--|---------------------|---|---|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Randolph Mitchell | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1-19 1986 | | | | 2b. HOUR 2:02 a.m. | |
| 3. SEX M | 4. RACE B | 5. DATE OF BIRTH MONTH DAY YEAR 3 17 58 | 6. AGE (IN YEARS LAST BIRTHDAY) 27 YRS. | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1-19 1986 | | 7d. HOUR 2:02 a.m. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital - DOA | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1037 BETHUNE ROAD 21225 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST BILLY MITCHELL JR. | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LILLIE MAE JONES | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. UNKNOWN | | 17. INFORMANT ADDRESS LILLIE MAE ADAMS 1037 BETHUNE RD. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxic Encephalopathy during general Anesthesia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | |
| 19a. DATE OF OPERATION 11-14-82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cutting wound of penis (subject Assaulted) 11/14/82 | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3 P.M. 11/14/82 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Therapeutic Misadventure | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Hospital | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 22 S. Greene St., Balto. Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE <i>Dennis F. Smyth</i> | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 1-19-86 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 1-24-86 | | 23c. NAME OF CEMETERY OR CREMATORY MOUNT AUBURN | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS WM.C.MARCH F/H INC. 1101 E. NORTH AVE. | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. THESE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSPORT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M
 BP *26*
 DHMH 17
 (VR A15 ME (5))

JAN 23 1986

 Items 19b + 21b per phone with Dr. Smyth
 3/12/86 DAD

80% COTTON FIBER

MADE IN THE U.S.A.



023064

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) JOHNNIEMAE MOBLEY | | | 2a. DATE OF DEATH MONTH DAY YEAR Jan. 18 86 | | | 2b. HOUR MIN. 11 37 P M | | | |
| 3. SEX Female | | 4. RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR 6 9 1925 | | 6. AGE (IN YEARS LAST BIRTHDAY) 60 | | 7. IF UNDER 1 YEAR MONTHS DAYS YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | | | |
| 10. CITY OR TOWN OF DEATH Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic | | 12b. KIND OF BUSINESS OR INDUSTRY Home | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Md | | 13b. COUNTY Balto | | 13c. CITY OR TOWN Turners | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 406 Avondale 21222 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST UNK. | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Queen Thompson | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 248-36-0640 | | 17. INFORMANT ADDRESS Oscar Mobley 406 Avondale | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Esophageal carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/18 , 19 86 , to 1/18 , 19 86 , that (I) (we) last saw the deceased alive on 1/18 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Lea Stern MD | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 1/19/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) LEA STERN | | | | 22e. ADDRESS 4940 EASTERN AVE BALTIMORE MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-23-86 | | 23c. NAME OF CEMETERY OR CREMATORY Arbutus | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto Md. | | | |
| 24. FUNERAL DIRECTOR NAME Jas. A. Morton + Sons | | | | ADDRESS 1701 Laurens | | 25a. DATE REC'D. BY REGISTRAR JAN 21 1986 | | 25b. REGISTRAR'S SIGNATURE J. K. ... | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1 - FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|-----------------|--|-------|--|------|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| Martha | | A. | | Mobley | | | | 1 | | 20 | | 86 | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | | | | | |
| Female | | Black | | 2 9 1921 | | 64 YRS. | | MONTHS | | DAYS | | HOURS | | MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| North Carolina | | U.S.A. | | | | Baltimore city | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Baltimore | | University of Maryland Hospital | | Unemployed | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | | | | | | | |
| Maryland | | | | Baltimore | | | | 1719 N. Pulaski St. 21223 | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| Andrew | | Olivia | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| No | | 241-32-9529 | | Bobby Mobley | | 6517 Kennison Ave. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF (b) | | DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| | | Respiratory Failure | | Renal Failure | | Cerebral Cancer | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | |
| | | 1-20-86 | | Boice | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| Burial | | | | Back Swamp Cemetery | | Williamston, N. Carolina | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. SIGNATURE | | | | | | | | | | | | | |
| Bailey-Douglass Funeral Home 1348 N. Calhoun St. | | JAN 21 1986 | | [Signature] | | | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coffin papers. Pages 1 and 2 must be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

131250

Secretary of the
Board of Directors
General Counsel

Mr. J. M. [unclear]
[unclear] [unclear] [unclear]
[unclear] [unclear] [unclear]

010136

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|--|---|--|--|---|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) JACOB MOODMAN | | | 2a DATE OF DEATH MONTH DAY YEAR 1 - 3 - 1986 | | 2b HOUR 1140 P.M. | |
| 3 SEX MALE | 4 RACE CAUCASIAN | 5 DATE OF BIRTH MONTH DAY YEAR MARCH 15, 1900 | | 6 AGE (IN YEARS LAST BIRTHDAY) 85 YRS | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | | |
| 10 CITY OR TOWN OF DEATH BALTO | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LEVINDALE AGED HOME | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PRINTER | | 12b. KIND OF BUSINESS OR INDUSTRY BELVEDERE HOTEL | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD 13b COUNTY BALTO 13c CITY OR TOWN BALTO | | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS / ZIP CODE 2500 W. BELVEDERE AVE., APT. 221 21215 | |
| 14 FATHER'S NAME FIRST MIDDLE LAST JOSEPH MOODMAN | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RACHEL UNKNOWN | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b SOCIAL SECURITY NO. 212-01-3822 | | 17 INFORMANT ADDRESS MR. ZALMEN J. BIRNBAUM 204 W. MONUMENT ST 21201 | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) GI bleeding DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC SARCOMA DUE TO, OR AS A CONSEQUENCE OF (c) yr Approximate interval between onset and death: 1 wk | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9/20 1985 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a I certify that (I) (this hospital) attended the deceased from 9/20 1985 to 1-3 1986 that (I) (we) lost saw the deceased alive on 1-3 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b SIGNATURE [Signature] | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED |
| 22d PHYSICIAN'S NAME, (TYPE OR PRINT) B. ZANWILL, MD | | | | 22e ADDRESS Levin Dale Geriatric Center 21215 | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b DATE 1/5/86 | | 23c NAME OF CEMETERY OR CREMATORY MOGAN ABRAHAM CEM | | 23d LOCATION ROSEDALE BALTO MARYLAND |
| 24 FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO, MD 21215 | | | | 25a DATE REC'D. BY REGISTRAR JAN 8 1986 | | 25b REGISTRAR'S SIGNATURE [Signature] |

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100% COTTON

021028

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 1 3 9 1

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|--|--|---|---|--|------------------------------------|----------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) <i>Jesse Milton Moody Sr.</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>1-10-86</i> | | | 2b. HOUR <i>7:40A</i> M | | | | | |
| 3. SEX <i>Male</i> | | 4. RACE <i>Black</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>5-12-19</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>66</i> YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (COUNTRY) <i>Virginia</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>St. Agnes Hosp</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <i>Retired</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <i>Maryland</i> | | | 13b. COUNTY <i>BALTO.</i> | | 13c. CITY OR TOWN <i>BALTO.</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Harry Moody</i> | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Frances Williams</i> | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE BRANCH AND DATES) <i>No.</i> | | | | | |
| 16b. SOCIAL SECURITY NO. <i>220-05-9278</i> | | | 17. INFORMANT <i>Mrs. Kula Moody</i> | | | ADDRESS <i>510 N. Denison St</i> | | | 21229 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardio-respiratory failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>cong. heart failure & renal failure</i> DUE TO, OR AS A CONSEQUENCE OF <i>C.O. P.D.</i> (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1-17-85</i> , 19____, to <i>1-10-86</i> , 19____, that (I) (we) lost saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>Heard</i> | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED <i>1/10/86</i> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>(GARR)</i> | | | 22e. ADDRESS <i>St. Agnes Hosp. Balto Md</i> | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | | 23b. DATE <i>1-15-86</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Arbutus Mem. Park</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>BALTO. Co. Md.</i> | | | | |
| 24. FUNERAL DIRECTOR NAME <i>Joseph L. Russ</i> | | | | | | ADDRESS <i>2222 W. North Ave.</i> | | 25a. DATE REC'D. BY REGISTRAR <i>JAN 17 1986</i> | | 25b. REGISTRAR'S SIGNATURE | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner should be notified at _____

BP

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|---|--|---|--------------------------------|--|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE A. LAST MOONEY | | | 2a. DATE OF DEATH MONTH DAY YEAR 01/ 07/ 86 | | | 2b. HOUR 8:30A M | | | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 02/ 15/ 1929 | | 6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENN. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore, City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Melchor Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) waitress | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | 13b. COUNTY -- | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 411 W. 28th St. Baltimore, Md. XXXX 21211 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Chmiet | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eleanore Charnesky | | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 188-22-2524 A | |
| 17. INFORMANT ADDRESS Baltimore, Md. | | | | 17. INFORMANT ADDRESS Baltimore, Md. | | | | 17. INFORMANT ADDRESS Baltimore, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Res. Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>End Stage Parkinson's Disease</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April 1</u> , 19 <u>85</u> , to <u>January 7</u> , 19 <u>86</u> , the (I) (we) lost saw the deceased alive on <u>Dec 22</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Neal M. Friedlander, M.D.</u> | | | | | | DEGREE | | | 22c. DATE SIGNED 1/8/86 | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Neal M. Friedlander, M.D.</u> | | | | | | 22c. ADDRESS <u>333 St. Paul Place, Suite 2A, Balto, Md 21202</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1/9/86 | | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | |
| 24. FUNERAL DIRECTOR NAME A. Alan Seitz, Jr. 3615-19 Chestnut Ave. 21211 | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 8 1986 | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use on the burial-transit permit. Then please remove the burial-transit permit from the certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition. IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

0021



016021

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <u>Emily R Moore</u> | | | 2a. DATE OF DEATH MONTH <u>1</u> DAY <u>8</u> YEAR <u>86</u> | | 2b. HOUR <u>10:10 AM</u> |
| 3. SEX <u>Female</u> | 4. RACE <u>Black</u> | 5. DATE OF BIRTH MONTH <u>11</u> DAY <u>18</u> YEAR <u>13</u> | 6. AGE (IN YEARS LAST BIRTHDAY) <u>72</u> YRS | | 7. UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u> |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Pennsylvania</u> | | 9. CITIZEN OF WHAT COUNTRY? <u>USA</u> | 10. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD. | | |
| 11. CITY OR TOWN OF DEATH <u>Baltimore</u> | 12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Univ. of Maryland Hosp. for</u> | | 13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Retired</u> | | 14. KIND OF BUSINESS OR INDUSTRY |
| 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 15a. STATE <u>Maryland</u> 15b. COUNTY <u>Balt. City</u> 15c. CITY OR TOWN <u>Baltimore</u> | | | 16. STREET ADDRESS / ZIP CODE <u>301 Mc Mechen St. Apt 316</u> | | |
| 17. FATHER'S NAME FIRST <u>Nelson</u> MIDDLE <u>Smith</u> LAST <u>Beatrice</u> | | 18. MOTHER'S MAIDEN NAME FIRST <u>Beatrice</u> MIDDLE <u>Jackson</u> LAST <u>Jackson</u> | | | |
| 19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u> | | 20. SOCIAL SECURITY NO. <u>121-05-7981</u> | | 21. INFORMANT ADDRESS <u>Robert Moore 301 Mc Mechen St Apt 316</u> | |
| 22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Gram-negative bacilli</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Lymphoma</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>4 weeks</u> <u>3 months</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Renal Failure, Respiratory Failure, Hemorrhage</u> | | | | | |
| 23. DATE OF OPERATION | | 24. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 25. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 26. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 27. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 28. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | |
| 29. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 30. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 31. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 32. I certify that (I) (this hospital) attended the deceased from <u>Dec 4</u> 19 <u>85</u> , to <u>Jan 8</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>Jan 8</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death) | | | | | |
| 33. SIGNATURE <u>Russell R. DeLuca MD</u> | | | | 34. DATE SIGNED <u>1/13/86</u> | |
| 35. DECEASED'S NAME (TYPE OR PRINT) <u>Russell R. DeLuca</u> | | | | 36. ADDRESS <u>22 South Greene St.</u> | |
| 37. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 38. DATE <u>1/14/86</u> | | 39. NAME OF CEMETERY OR CREMATORY <u>Garrison Forest Vet</u> | |
| 40. LOCATION CITY OR TOWN COUNTY STATE <u>Wings Mills Md</u> | | 41. FUNERAL DIRECTOR NAME <u>William C. March F/H West 4300 Wabash Avenue</u> | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

029025

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

6

01394

REG. NO.

| | | | | | |
|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) ERWIN T. MOORE | | 2a. DATE OF DEATH MONTH DAY YEAR 1 24 86 | | 2b. HOUR 6:30 AM | |
| 3. SEX M | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 12 07 28 | | 6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANCIS SCOTT KEY MEDICAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNEMPLOYED | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE MD | | 13b. COUNTY BALTIMORE | | 13c. STREET ADDRESS / ZIP CODE 1836 CLIFTON AVE. 21217 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JASPER MOORE | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ETTA DOBY | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 213-28-1965 | | 17. INFORMANT ADDRESS ISABELLE AUSTON 1836 CLIFTON AVE. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>aspiration pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerotic brain damage</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>hypertensive crisis</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 4</u> , 19 <u>86</u> , to <u>Jan 23</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>1/23/86</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | |
| 22b. SIGNATURE Brenda W. Cooper MD | | | | 22c. DATE SIGNED 1/24/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Brenda W. Cooper MD | | | | 22e. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 1/29/86 | | 23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD | | 24. FUNERAL DIRECTOR NAME ADDRESS WM. C. MARCH FUNERAL HOME 1101 E. NORTH AVE. | | | |
| 25a. DATE REC'D. BY REGISTRAR JAN 27 1986 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

BP

020020

008164

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01395

REG. NO.

| | | | | | | | | | | | | | | | | | |
|--|---------|--|--|---|--|---|--|---|--|--------------------------|--|---|--|------|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| Horace | | Moore | | | | | | 1/ 3/ 19 86 | | | | | | | | 1:35 | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | |
| Male | Black | July 12, 1959 | | 26 YRS. | | | | | | 1/ 3/ 19 86 | | | | | | A M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| Maryland | | U.S.A. | | WIDOWED | | DIVORCED | | Baltimore City | | | | | | | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Baltimore | | University Hospital Shock Trauma | | | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | |
| Maryland | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 838 Cherry Hill Rd. | | | | | | | | 21225 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| Horace | | Moore | | Mildred | | E. F. | | Moore | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| No | | N/A | | | | Mildred F. Moore | | 838 Cherry Hill Rd. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Multiple Gunshot Wounds | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | | | | |
| | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| | | | | ? P.M. 1/ 2/ 19 86 | | | | subject shot | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | street | | | | 1300 Blk. Blommingdale Rd., Balto. City, Md. | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| TITLE (SPECIFY) | | | | | | | | | | | | | | | | | |
| M.D. Assistant MEDICAL EXAMINER | | | | | | | | | | | | | | | | | |
| DATE SIGNED 1/3/86 | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. ADDRESS 111 Penn St. | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | | | |
| Burial | | | | 1/ 8/ 86 | | | | Woodlawn Cemetary | | | | Baltimore, Md. | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | | | | | | | | |
| NAME Leroy O. Dyett 4600 Liberty Hghts.Ave. ADDRESS | | | | | | | | | | | | | | | | | |
| 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | |
| JAN 6 1986 | | | | | | | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

07/B4
25MBP
DHMH - 17
(VR A15 ME (5))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGES 1 AND 2 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

11270

20% COTTON FIBER

MADE IN AMERICA



036162

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|---|--------|---|-------------------|---|-------|--|------|-----------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR | |
| REBECCA | | | L. | MOORE | 1/27/86 | | | | | 236A M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 72 HRS | |
| Female | | White | | MONTH DAY YEAR 6 26 1948 | | 37 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | | U.S.A. | | | | Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | Francis Scott Key Medical Center | | | | Housewife | | | | | |
| 13a. STATE | | | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | |
| Maryland | | | | Baltimore | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 1006 Bayner Road | | 21221 | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST Conley C. Bridges, SR. | | | | FIRST MIDDLE LAST Ida May Eybs | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | ADDRESS | | | | | |
| No | | 212-56-5666 | | Lloyd E. Moore | | Same as 13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypotension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>hypoxia</u> | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Renal Failure / Pneumonia - staph</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/23/86</u> , 19 <u>86</u> , to <u>1/27/86</u> , 19 <u>86</u> , that (I) (we) lost <u>✓</u> saw the deceased alive on <u>1/27/86</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>PATRICIA C. Harris</u> | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED <u>1/29/86</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>PATRICIA C. Harris</u> | | | | 22e. ADDRESS <u>FBKMC 4940 Eastern Ave</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN | | COUNTY STATE | | | |
| Burial | | 1/29/1986 | | Oak Lawn Cemetery | | Baltimore | | Maryland | | | |
| 24. FUNERAL DIRECTOR NAME | | | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Duda-Ruck, Inc. | | | | 7922 Wise Avenue Dundalk, Maryland 21222 | | JAN, 30, 1986 | | | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 01397

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | | | | |
|--|--|---|--|--|--|--|--|---|
| 1 DECEASED NAME (TYPE OR PRINT) WILMER A MORRISON Sr. | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 / 29 / 86 | | | 2b. HOUR 12:50 PM | | |
| 3 SEX Male | | 4 RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR 5 / 7 / 09 | | 6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH City of Baltimore MD | | |
| 10 CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Gardener | | 12b KIND OF BUSINESS OR INDUSTRY |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD | | 13b COUNTY | | 13c CITY OR TOWN Baltimore | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS / ZIP CODE 5505 Narcissus Ave 21215 |
| 14 FATHER'S NAME FIRST MIDDLE LAST William Morrison | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Hendrick | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE "R OR DATES) no | | | | 16b SOCIAL SECURITY NO. 160-28-6251 A | | 17. INFORMANT Mrs. Ann Morrison ADDRESS 5505 Narcissus Ave. Baltimore, MD. 21215 | | |

| | | | |
|---|--|--|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
|---|--|--|--|

| | | | |
|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic Obstructive Pulmonary Disease | | | |
|--|--|--|--|

| | | | | | | | |
|-----------------------|--|--|--|--|--|--|--|
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
|-----------------------|--|--|--|--|--|--|--|

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | |
|---|--|--|--|--|--|--|--|

| | | | | | |
|---|--|---|--|---|--|
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
|---|--|---|--|---|--|

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 22a I certify that (I) (this hospital) attended the deceased from 1/29 1/29, 19 86, to 1/29, 19 86, that (I) (we) last saw the deceased alive on He was dead on Arrival and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
|---|--|--|--|--|--|--|--|

| | | | | | | | |
|---------------------------------|--|--------|--|--|--|-----------------------------|--|
| 22b SIGNATURE R.E. PERRY, MD | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/29/86 | |
|---------------------------------|--|--------|--|--|--|-----------------------------|--|

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) R.E. PERRY, MD | | 22e ADDRESS Sinai Hosp Baltimore, MD 21215 | | | | | |
|--|--|---|--|--|--|--|--|

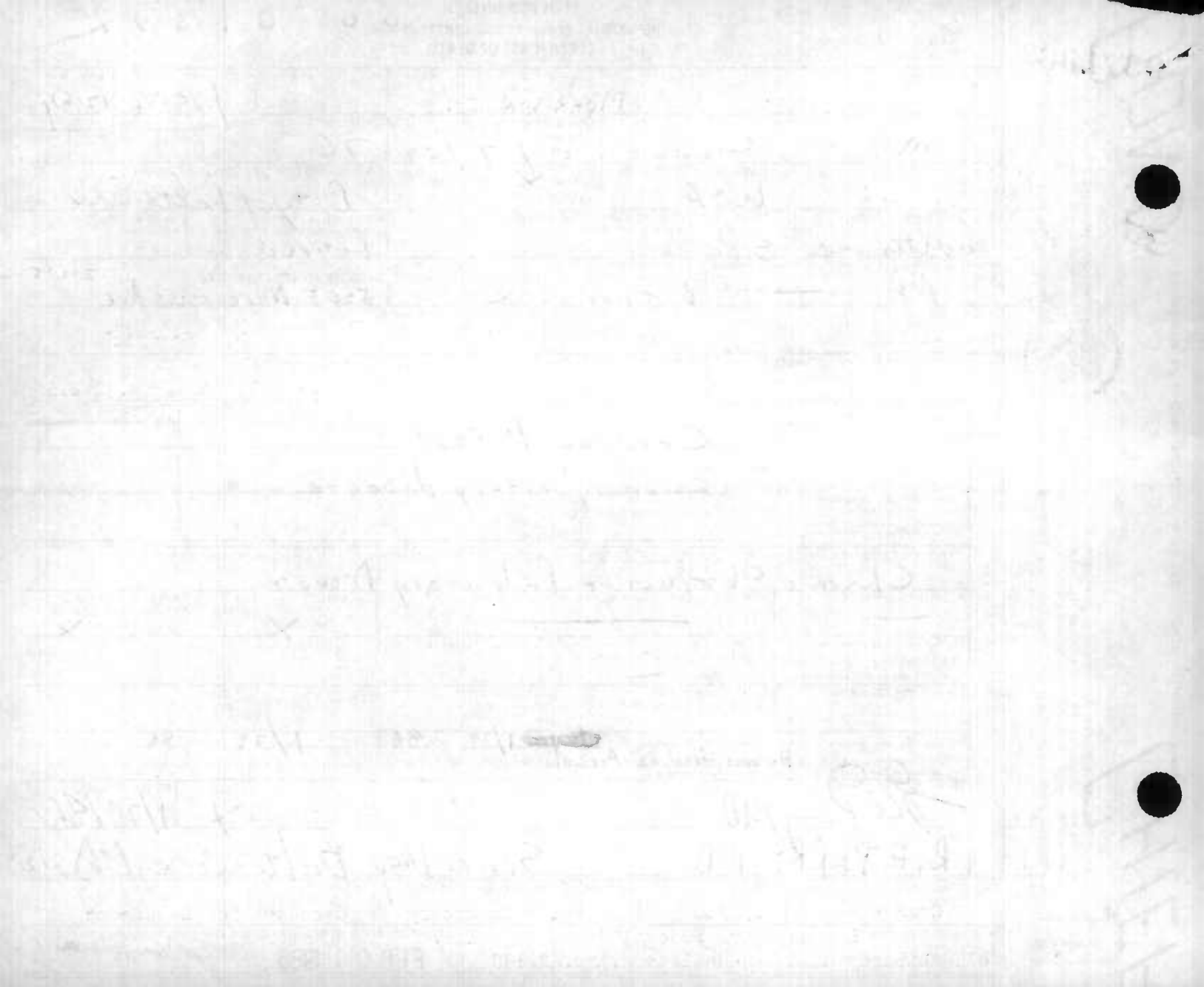
| | | | | | | | |
|---|--|---------------------|--|--|--|--|--|
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 2/3/86 | | 23c. NAME OF CEMETERY OR CREMATORY Westview Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Baltimore MD | |
|---|--|---------------------|--|--|--|--|--|

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 24 FUNERAL DIRECTOR Loring Byers Funeral Directors, Inc. NAME ADDRESS 8728 Liberty Road Randallstown, MD. 21133 | | | | 25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE FEB 04 1986 John Davidson-Randall | | | |
|---|--|--|--|---|--|--|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be immediately filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copies of pages 1, 2, 3 and 4. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



034005

Items 18 22a 3/21/86 mth F#613

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01398

REG. NO.

| | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|---------|-------|--|--|-------------------|--|--|-------|------------------|--|---|--|----------------|------------------|---|--|----------|--|----------------------------|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | | | MIDDLE | | | LAST | | | 2a. DATE KNOWN OF DEATH | | | X MONTH DAY YEAR | | | 2b. HOUR | | | | | |
| Vionus | | | | | | | | | Morse | | | 1/24/ 19 86 | | | A M | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH DAY YEAR | | 11:52 | | | | | | | |
| Female | | Black | | July 3, 39 | | 46 | | | | | | 1/ 24/ 19 86 | | A M | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| Maryland | | | | USA | | | | | | | | Baltimore City, | | | | MD | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Baltimore | | | | 2405 Huron Street (rear yard) | | | | | | | | | | | | | | | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? | | | | 13e. STREET ADDRESS | | | | | | | |
| Md. | | | | | | | | Balto. | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 2400 Annor Ct. 21230 | | | | | | | |
| 14. FATHER'S NAME | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| George Lewis | | | | | | | | Patsy M. Baskerville | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | | | | | | | | | |
| no | | | | | | | | 219-32-9719 | | | | Sterling Smith 108 N. Stricker St. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular disease | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost | | | | | | | | | | | | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | | | | | | | | | | | | |
| chronic alcoholism | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | 20. AUTOPSY? | | | | | | | |
| | | | | | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED | | | | (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, had an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | |
| TITLE (SPECIFY) | | | | | | | | | | | | | | | | | | | | | | | |
| M.D. Assistant MEDICAL EXAMINER | | | | | | | | | | | | | | | | | | | | | | | |
| DATE SIGNED 1/24/86 | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. | | | | | | | | | | | | | | | | ADDRESS 111 Penn St. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | | COUNTY STATE | | | | | | | |
| Burial | | | | 1/31/86 | | | | Cedar Hill Cemetery | | | | Brooklyn, A.C. | | | | Md. | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| NAME Charles A. Rice F.S.P.A. 1300 Euterio Pl | | | | | | | | | | | | | | | | JAN 30 1986 | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 1. RETURN TO THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201. IF FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
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(VR A15 ME (5))

U.S. DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

Very faint, illegible text covering the majority of the page, likely bleed-through from the reverse side. The text appears to be organized into paragraphs and possibly a table or list structure, but the characters are too light to transcribe accurately.

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V. K. P. P.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | | | | | |
|--|---------|------------------|---|-------------------|---------------------|--|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE KNOWN OF DEATH | | | MONTH DAY YEAR | | | 2b. HOUR | | |
| FIRST MIDDLE LAST LOUIS HENRY MOSMILLER | | | 1 19 86 | | | 0915 | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR. | 8. IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD | | | 2d. HOUR | | |
| Male | White | 1/20/1923 | 62 YRS. | | | 1 19 86 | | | 1150 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Maryland | | | U.S.A. | | | | | | Baltimore City MD | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | | | Francis Scott Key Medical Center | | | Machinist-Maryland | | | Dry Dock | | |
| 13a. STATE | | | 13b. CITY OR TOWN | | | 13c. INSIDE CITY LIMITS? | | | 13d. STREET ADDRESS | | |
| Maryland | | | Baltimore | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 7461 Manchester Road 21222 | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | 17. INFORMANT | | |
| FIRST MIDDLE LAST Louis Karl Mosmiller | | | FIRST MIDDLE LAST Elizabeth C. Goetze | | | (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II | | | Same as 13e | | |
| 16b. SOCIAL SECURITY NO. | | | 17. ADDRESS | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 219-18-6452 | | | Joan C. Mosmiller | | | PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: | | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE | | | TITLE (SPECIFY) | | | DATE SIGNED | | | | | |
| T. Crossan O'Donovan | | | Deputy | | | 1/19/86 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | ADDRESS | | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | |
| T. CROSSAN O'DONOVAN | | | 242 Dundalk Ave., Balt., Md. 21222 | | | Cremation | | | 1/23/1986 | | |
| 24. FUNERAL DIRECTOR NAME | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Duda-Ruck, Inc. | | | JAN 21 1986 | | | Baltimore Maryland | | | | | |
| 7922 Wise Avenue Dundalk, Maryland 21222 | | | | | | | | | | | |

07/84
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DHMH - 17
(VR A15 ME (5))

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 1 4 0 1

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Conrad Leroy Muhl | | | 2a. DATE OF DEATH MONTH DAY YEAR January 25, 86 | | 2b. HOUR 8:15A |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 12 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY) 84 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? United States | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore Gen. Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chauffer | | 12b. KIND OF BUSINESS OR INDUSTRY Trucking |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Balto. Highland | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Conrad Muhl | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca Meter | | 13e. STREET ADDRESS / ZIP CODE 2815 Florida Ave 21237 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 213.01.2884 | | 17. INFORMANT ADDRESS Glen Burnie Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Failure DUE TO, OR AS A CONSEQUENCE OF (b) Treatment for urinary tract infection DUE TO, OR AS A CONSEQUENCE OF (c) Inanition. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Inanition Pneumonia. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from December 30, 1985 , to January 25, 1986 , that (I) (we) last saw the deceased alive on January 25, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Rafael E. Espinosa | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/25/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rafael E. Espinosa | | 22e. ADDRESS 3001 South Hanover St. Baltimore, MD 21230. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Jan. 28, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Singleton Funeral Home, Glen Burnie, Maryland | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | 25a. DATE REC'D. BY REGISTRAR JAN 28 1986 | |
| | | | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, medical attention should be given to the body.

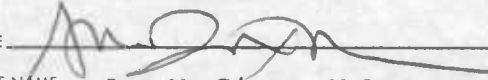
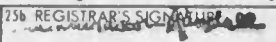
07015-01020

013006

FOR
1- STATE
REGISTRAR
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01402

REG. NO.

| | | | | |
|---|-------------------------|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) CATHRYN F. MULCAHY | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 6 1986 | | 2b. HOUR AM |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 12--28--01 | 6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 85 | 7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 9. CITIZEN OF WHAT COUNTRY? U.S.A. | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 11. CITY OR TOWN OF DEATH Baltimore | | 12. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1027 Cathedral St. | | 13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse |
| 14. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY ----- | | 13c. CITY OR TOWN Baltimore |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1027 Cathedral St. 21201 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Thomas Mulchay | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Murphy | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 214-26-6346 | | 17. INFORMANT ADDRESS Miss Marie Eby 21 W. Susquehanna Ave. 21201 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) ----- DUE TO, OR AS A CONSEQUENCE OF (c) ----- | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | |
| ACTUAL SIGNATURE  | | TITLE (SPECIFY) M.D. Assistant | | DATE SIGNED 1-8-86 |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | ADDRESS 111 Penn St., Balto., MD 21201 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-11-86 | | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral |
| 23d. LOCATION CITY OR TOWN Baltimore City | | COUNTY Maryland | | |
| 24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home | | ADDRESS 6500 York Road 21212 | | 25a. DATE REC'D BY REGISTRAR JAN 9 1986 |
| | | | | 25b. REGISTRAR'S SIGNATURE  |

DIVISION OF VITAL RECORDS, 201 W. PRESHOT ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PLACE OF ITEM 8. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TREATMENT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESHOT STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18, the medical examiner must be notified of any injury, or other traumatic event, that may have contributed to the death.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 1 4 0 3

REG. NO.

| | | | | | |
|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Betty I. Mullen | | 2a. DATE OF DEATH MONTH DAY YEAR 01 10 86 | | 2b. HOUR 639 M | |
| 3 SEX Female | | 4 RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 02 10 23 | |
| 6 AGE (IN YEARS LAST BIRTHDAY) 62 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS 02 10 23 | | 8. IF UNDER 1 YEAR HOURS MIN 639 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA. | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF LIFE) Housewife | |
| 13a. STATE MD | | 13b. COUNTY Harford | | 13c. CITY OR TOWN Brooklyn | |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 4122 Audrey Ave | | 13f. ZIP CODE (21225) | |
| 14. FATHER'S NAME Michael Toshok | | 15. MOTHER'S MAIDEN NAME Helen Tesko | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | |
| 16a. SOCIAL SECURITY NO. 195186196 | | 17. INFORMANT Billie Lewis | | 17. ADDRESS 4122 Audrey Ave. (21225) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) severe upper Respiratory infection DUE TO, OR AS A CONSEQUENCE OF (c) exacerbation COPD, myocardial infarction PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22. I certify that (a) this hospital attended the deceased from 12/27 19 85 to 1/10 19 86 , that (b) I last saw the deceased alive on 1/10 19 86 , and that in my professional opinion death occurred on the date and hour and from the causes stated above. | | | | | |
| 22a. SIGNATURE J. Griffin | | 22b. PHYSICIAN'S NAME (TYPE OR PRINT) J. Griffin | | 22c. ADDRESS 3001 South Hanover St | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/13/1986 | | 23c. NAME OF CEMETERY OR CREMATORY Holly Hill Mem. Gar. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Middle River, Baltimore Co., MD | | 24. FUNERAL DIRECTOR NAME ADDRESS George J. Gonce, 4001 Ritchie Hg., Baltimore, MD. | | | |

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

JAN 13 1986

REGISTRAR'S SIGNATURE

480010

1

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|---|---|--|--|---|------------------------------|--|------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR |
| WILLIAM P. MULLIN | | | | | 1 | 30 | 86 | | 8 ³³ PM |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | |
| MALE | WHITE | APRIL 5 1903 | | 82 | MONTHS | DAYS | HOURS | MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| MD. | U.S.A. | | | BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| BALTIMORE | UNION MEMORIAL HOSPITAL | | PATROLMAN | | POLICE DEPT. | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE | | | | |
| MD. | | JOES | BALTIMORE | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 504 E. 39th ST. 21218 | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| WILLIAM T. MULLIN | | ELLA FOY | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | | ADDRESS | | | | | |
| NO | 219-32-5927 | DOLORES OSTROWSKI (DGHTER) | | 3605 E. JOPPA RD. 21234 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Cardiopulmonary Collapse</u> | | | | | | | | | 30 min |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | 7 d |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) <u>ARF.</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JAN 30</u> , 19 <u>86</u> , to <u>JAN 30</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>JAN 30</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | 22c. DATE SIGNED | | |
| <u>Robert H. Brown</u> | | | | MD | | | 1/30/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | |
| | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| BURIAL | | 2/3/86 | | ST. MARY OF THE ASSUMPTION | | BALTIMORE MD. | | | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| SCHIMUNEK FUNERAL HOME, INC. 3331 Brehms Lane, Balto. Md. 21213 | | | | JAN 31 1986 | | <u>John Davidson-Randall</u> | | | |

MEDICAL CERTIFICATION

100-1000



010118

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this page to the State Dept. of Health and Mental Hygiene with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE REGISTRAR **Alonzo C. Murphy**

| | | | | | |
|---|--|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) Alonzo Murphy | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 4 86 | | 2b. HOUR 4:40 PM |
| 3 SEX Male | 4 RACE White | 5. DATE OF BIRTH MONTH DAY YEAR March 25 1900 | 6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) West Virginia | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter | 12b. KIND OF BUSINESS OR INDUSTRY Construction | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Dundalk | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS 7906 Lynch Rd. 21222 |
| 14. FATHER'S NAME FIRST Henry Poole Murphy | | | 15. MOTHER'S MAIDEN NAME Harriet Fazenbaker LAST | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN) No (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. 216 07 8455 | 17. INFORMANT Joann Murphy ADDRESS Same | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest 2° to DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension 2° to Acute Congestive DUE TO, OR AS A CONSEQUENCE OF (c) Heart failure and Pulmonary Edema | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Rheumatoid Lung disease | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/4 19 86 to 1/4 19 86 , that (I) (we) lost saw the deceased alive on 1/4 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Dr. P. Myers, MD. | | | DEGREE MD. | | 22c. DATE SIGNED 1/4/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | |

| | | | |
|--|----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (b) Burial | 23b. DATE 1/7/86 | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Pk. | 23d. LOCATION CITY OR TOWN COUNTY STATE Howard Co., Md. |
| 24. FUNERAL DIRECTOR Brudzinski Funeral Home | | 25a. DATE REC'D. BY REGISTRAR JAN 8 1986 | 25b. REGISTRAR'S SIGNATURE J. H. Anderson-Randall |

Washington City

USA

West Virginia

Commissioner

South Atlantic General Hospital

Washington

7005 Fourth St. SE

x

Landmark Baltimore

President

James

James Lusk

James

James Lusk

James

James G. Lusk

Washington General Hospital

1952

James

Washington General Hospital

009101

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate from the file and send it to the funeral home. The State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

01406

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME FIRST MIDDLE LAST SARA H MURPHY | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 05 1986 | | | 2b. HOUR 2:45 PM | |
| 3. SEX Female | | 4. RACE Negro | | 5. DATE OF BIRTH MONTH DAY YEAR 12 18 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) S B G H | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) none | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |

| | | | | | | | | | | | |
|---|--|-------------|--|---|--|--|--|---|--|--|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS / ZIP CODE 808 ST. Paul Street 21202 | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Hillard unknown Chase Boro | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown Nealie McTherson | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) UNKNOWN | | | | 16b. SOCIAL SECURITY NO. 140-22-5216 | | 17. INFORMANT ADDRESS MILLIE SHIPPEN | | | | | |

| | | | |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) sepsis DUE TO, OR AS A CONSEQUENCE OF (c) chronic pyelonephritis | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
|--|--|---|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/3/86, 19 86, to 1/5/86, 19 86, that (I) (we) lost saw the deceased alive on 2:45 1/5 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Basil E. Crayssos M.D. | | | | DEGREE | | 22c. DATE SIGNED 1/5/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Basil E. Crayssos M.D. | | | | 22e. ADDRESS S B G H | | | |

| | | | | | | | |
|--|--|----------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-11-86 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | |
| 24. FUNERAL DIRECTOR BROWN-TOMPSON R. A. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 7 1986 | | 25b. REGISTRAR'S SIGNATURE | |

10-5-60



016120

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) JOSEPH W. MURRAY | | | 2a. DATE OF DEATH MONTH DAY YEAR 1/10/86 | | 2b. HOUR 12:30 AM |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 5 1935 | 6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION Reconsideration Staff Manager | | 12b. KIND OF BUSINESS OR INDUSTRY Soc. Sec. Admr. |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | 13b. CITY OR TOWN Harford | | |
| 13c. CITY OR TOWN Baldwin | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Leo Aloysius Murray Sr. | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Agnes Doxzen | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. 212 34 0283 | | 17. INFORMANT ADDRESS 21013 Mrs. Sue Ellen Murray 2746 Glen Elyn Way | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Pulmonary Arrest. DUE TO, OR AS A CONSEQUENCE OF (b) UGI bleed DUE TO, OR AS A CONSEQUENCE OF (c) myelodysplastic Disorder APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Thrombocytopenia, Anemia | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 26 1985 to Jan 10 1986 that (I) (we) last saw the deceased alive on Jan 10 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>[Signature]</i> | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/10/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) John P. Serlemiotis | | 22e. ADDRESS Union Memorial Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Jan 13, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral Ceme. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | | | | |
| 24. FUNERAL DIRECTOR J. E. Lowell Lemmon | | ADDRESS Padonia & York Rds. | | 25a. DATE REC'D. BY REGISTRAR JAN 13 1986 | |
| 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.

BP _____

RECEIVED JAN 11 1962

WINTER 1962

Jan 13, 1962
New York School of Social Work
New York, N.Y.

024028

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in the funeral director's office. It should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | |
|---|--|---|--|--|--|
| 1- FOR STATE REGISTRAR | | 1 DECEASED NAME (TYPE OR PRINT) MARIE Marie Lillian MYERS | | 2a DATE OF DEATH MONTH DAY YEAR JANUARY 19, 1986 | |
| 3 SEX Female | | 4 RACE White | | 2b HOUR 2:10 PM | |
| 5. DATE OF BIRTH MONTH DAY YEAR Jan. 9, 1899 | | 6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS | | IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto., Md. | | 7b CITIZEN OF WHAT COUNTRY? U. S. A. | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD | |
| 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 10 CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital | |
| 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b KIND OF BUSINESS OR INDUSTRY --- | | 13a STATE Md. 13b COUNTY --- 13c CITY OR TOWN Baltimore | |
| 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS / ZIP CODE 9 N. Milton Ave.-21224. | | 14 FATHER'S NAME FIRST MIDDLE LAST Charles --- Hoffman | |
| 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian R. Hartlove | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b SOCIAL SECURITY NO. 216-01-1358 | |
| 17 INFORMANT Balto., Md. ADDRESS 21224. | | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) STATUS POST MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) --- | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: --- | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (this hospital) attended the deceased from JANUARY 3, 1986 to JANUARY 19, 1986 , that (I) (we) last saw the deceased alive on JANUARY 19, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE Bram D. Zuckerman | | DEGREE --- | | 22c DATE SIGNED 1/19/86 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) BRAM ZUCKERMAN MD | | 22e ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTO. MD. 21231 | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b DATE 1/23/86 | | 23c NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem.-Baltimore, Md. | |
| 23d LOCATION CITY OR TOWN COUNTY STATE | | 24 FUNERAL DIRECTOR NAME John A. Moran, Inc. Funeral Home ADDRESS 3000 E. Baltimore St.; Balto., Md. 21224 | | | |
| 25 REC'D. BY REGISTRAR | | 25 REGISTRAR'S SIGNATURE Jake Davidson-Randall | | JAN 22 1986 | |

MEDICAL CERTIFICATION

050740

11/11/15

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050740

050740

11/11/15

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020053

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Vera Lee Myers</u> | | | 2a. DATE OF DEATH MONTH DAY YEAR <u>JAN. 8 - 86</u> | | | 2b. HOUR <u>11:30 AM</u> | |
| 3. SEX <u>Female</u> | | 4. RACE <u>Black</u> | | 5. DATE OF BIRTH MONTH DAY YEAR <u>Sept. 25 - 05</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. <u>80</u> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Va.</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD. | |
| 10. CITY OR TOWN OF DEATH <u>Baltimore</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>1702 E. Lafayette Ave.</u> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>P. Nurse</u> | |
| 12b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u> | | | | | | | |
| 13a. STATE <u>md.</u> | | 13b. COUNTY <u>Baltimore</u> | | 13c. CITY OR TOWN <u>Baltimore</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE <u>1702 E. Lafayette Ave. 21213</u> | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <u>John Spratley</u> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Lue Emma Godwin</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u> | | 16b. SOCIAL SECURITY NO. <u>214-30-5144</u> | | 17. INFORMANT ADDRESS <u>Titus Spratley 1702 E. Lafayette Ave.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Ischemic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>5 years</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Obstructive Pulmonary Disease</u> | | | | | | | |
| 19a. DATE OF OPERATION <u>June 29, 1986</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Coronary Artery Bypass</u> | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 29, 1986</u> , to <u>June 8, 1986</u> , that (I) (we) last saw the deceased alive on <u>June 7, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Roland T. Smoot, M.D.</u> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>1/10/86</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ROLAND T. SMOOT, M.D.</u> | | | | 22e. ADDRESS <u>2300 GARRISON BLVD. 21216</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>1-13-86</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem. Park</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore Md.</u> | |
| 24. FUNERAL DIRECTOR NAME <u>Randolph J. Collick</u> | | | | ADDRESS <u>2431 E. Oliver St.</u> | | 25a. DATE REC'D. BY REGISTRAR <u>IAN 16 1986</u> | |
| | | | | 25b. REGISTRAR'S SIGNATURE <u>Lelia Davidson-Rodale</u> | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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INDEX

10/1/1911

10/1/1911

10/1/1911

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
ADVISE THE MEDICAL EXAMINER BY TELEPHONE. WRITE THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAPERS 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
TO FUNERAL DIRECTOR: PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER IN A FOLDER ALONG WITH FORMS PM-3, RETAIN PAGE 6 FOR YOUR FILES.
PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS,
WITH THE STATE DEPARTMENT OF HEALTH AND MEDICAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. WESTON STREET,
MILWAUKEE, WISCONSIN 53233.

BP_____

DHMH - 17
(VR A15 ME (5))

| | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|--|--|---|--|---|--|
| FOR 1- STATE REGISTRAR | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MEDICAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 01410 REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Michelle MARIE Nakkula | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTI. MATED 1/31/86 | | | | 2b. HOUR 12:25 | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR 1/18/86 | | 6. AGE (IN YEARS) (LAST BIRTHDAY) 18 YRS. | | 7. IF UNDER 1 YR. MONTHS DAYS | | 8. IF UNDER 24 HRS. HOURS MIN. | | 9. DATE PRONOUNCED DEAD 1/31/86 | | 10. HOUR A M. | |
| 7a. BIRTHPLACE (STATE OR CITY OR TOWN) MARYLAND | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital Shock Trauma | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary | | | | 12b. KIND OF BUSINESS OR INDUSTRY NAVAL ACAD. LIBRARY | | | |
| 13a. STATE Maryland | | | | 13b. COUNTY Anne Arundel | | 13c. CITY OR TOWN Millersville | | 13d. INSIDE CITY LIMITS <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES | | 13e. STREET ADDRESS 10 Jumpers Hole Rd | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Douglas J. Nakkula | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy M. Craycraft | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 215042421 | | 17. INFORMANT Douglas NAKKula (SAME AS ABOVE #13e) | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR MONTH DAY YEAR 4:01 P.M. 1/24/86 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver of auto/auto collision | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt. 2 & Chestnut St., Pasadena, Anne Arundel, Md. | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE [Signature] | | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | | | | | | | DATE SIGNED 1/31/86 | |
| EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. | | | | ADDRESS 111 Penn St. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial | | | | 23b. DATE 2-3-86 | | 23c. NAME OF CEMETERY OR CREMATORY MD Veterans Cem. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville, A.A. MD | | | | | |
| 24. FUNERAL DIRECTOR NAME BARRANCO F.H. | | | | 25. DATE REC'D. BY REGISTRAR FEB 05 1986 | | | | 26. REGISTRAR'S SIGNATURE John Davidson | | | | | | | |

3456789

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FLORINDA NAPOLITANO | | | 2a. DATE OF DEATH MONTH DAY YEAR JAN 2 86 | | | 2b. HOUR 1205 A.M. | |
| 3. SEX FEMALE | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR FEB. 5 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS MONTHS DAYS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ITALY | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | |

| | | | | | | | | | | | | | | |
|---|--|--|-----------------------------|--|--|--|--|--|---|--|--|--|--|--|
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | | 13b. COUNTY BALTO | | | 13c. CITY OR TOWN REISTERSTOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE 1 COLISTON RD 21136 | | |
|---|--|--|-----------------------------|--|--|--|--|--|---|--|--|--|--|--|

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|--|--|--|--|--|--|
| 14. FATHER'S NAME FIRST MIDDLE LAST FRANK LAVERGHETTA | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MICHEALA D'ADAMO | | |
|--|--|--|--|--|--|

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|---|--|---|--|---|--|--|--|
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-09-5174 | | 17. INFORMANT MARY C. GUERCIO | | ADDRESS 1600 S. EADS ST 605N ARLINGTON VA. 22202 | |
|---|--|---|--|---|--|--|--|

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|---|--|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE | | DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
|---|--|--|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

GASTROINTESTINAL BLEEDING 2° DIVERCULAR DISEASE

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION 12/15/85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED AS ABOVE PART 2 | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
|---|--|--|--|--|--|--|--|

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|--|--|---|--|--|--|--|--|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
|--|--|---|--|--|--|--|--|

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
|--|--|--|--|---|--|--|--|

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 22a. I certify that (1) this hospital attended the deceased from 12/12 , 19 85 , to 1/1 , 19 86 , that (1) (we) last saw the deceased alive on 1/1 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | | | |
|--|--|--|--|--|--|--|--|

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|--------------------------------------|--|---------------------|--|--|--|-----------------------------------|--|
| 22b. SIGNATURE J. A. Mason | | DEGREE MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/2/86 | |
|--------------------------------------|--|---------------------|--|--|--|-----------------------------------|--|

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. A. MASON | | 22e. ADDRESS MERCY HOSPITAL ST. PAUL PLACE BALTO. MD. | | | | | |
|---|--|---|--|--|--|--|--|

| | | | | | | | |
|---|--|----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 1/6/86 | | 23c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD | |
|---|--|----------------------------|--|--|--|---|--|

| | | | | | | | |
|---|--|---------------------------------|--|---|--|---|--|
| 24. FUNERAL DIRECTOR NAME WEBER FUNERAL HOME | | ADDRESS EDMONDSON AVE | | 25a. DATE REGD. BY REGISTRAR JAN 7 1986 | | REGISTRAR'S SIGNATURE [Signature] | |
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page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|--|---|--|-----------------------------------|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | MONTH DAY YEAR | |
| JOSEPHINE R. NEAT | | | | | | | | 1/2/86 6:50P M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| Female | | White | | MONTH DAY YEAR 6 22 24 | | 61 YRS | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Pennsylvania | | USA | | | | Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | St. Agnes Hospital | | | | Homemaker | | --- | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | | |
| Maryland | | Baltimore | | Lansdowne | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. SOCIAL SECURITY NO. | | | | | |
| FIRST MIDDLE LAST James Willders | | FIRST MIDDLE LAST Sarah Finneyfrock | | 205-16-4562 | | | | | |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 18. INFORMANT | | ADDRESS | | | | | |
| No | | Thelma Furlong, 1949 Victory Dr., 21227 | | | | | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>cardio-pulmonary arrest</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEPSIS</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>ACUTE RENAL FAILURE</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>DIABETES, HYPERTENSION, STATUS POST GASTROSTOMY</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| 12/18/85 | | GASTRIC ULCER | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| | | HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.] | | STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>21 NOVEMBER 19 85</u> , to <u>2 JANUARY 19 86</u> , that (I) (we) last saw the deceased alive on <u>2 JANUARY 19 86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | | | |
| <u>Ed Chambers MD</u> | | MD | | 1/2/86 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | |
| Dr. Edford Chambers Md. | | 900 CATON AVE, BALTIMORE, MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| Burial | | 1-6-86 | | Meadowridge Mem. Pk | | CITY OR TOWN COUNTY STATE Elkridge Howard Md. | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| NAME ADDRESS Hubbard Funeral Home, Inc., 4107 Wilkens Ave. | | 21229 | | JAN 6 1986 | | | | | |

003128



ADJUTANT GENERAL

W. H. HARRIS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be placed in the funeral director's office. The funeral director, after filling in the space provided, should be ready within 72 hours after death to take the body to the funeral home for preparation. Pages 1 and 2 should be retained by the funeral director. Pages 3 and 4 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

99

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO

| | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|-----------------|--|------|--|-------|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| EARL | | S | | NEUHAUSER | | | | 1 | | 11 | | 86 | | 1:53A | | M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | | | | | |
| Male | | WHITE | | Nov. 7, 1923 | | 62 | | YRS. | | MONTHS | | DAYS | | HOURS | | MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| Maryland | | U.S.A. | | | | BALTIMORE CITY | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| BALTIMORE | | VAMC, Baltimore, Maryland 21218 | | AT HOME | | | | | | | | | | | | | |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE | | | | | | | | | |
| Maryland | | BALTIMORE | | PERRY HALL | | | | 3865 SCHROEDER AVE. | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | | | | | | | | | | | | | |
| 2. Samuel H. Neuhauser | | Josephine A. Ayres | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| YES | | W.W.H. | | 21618 6262 | | FAMILY RECORDS | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <u>Respiratory failure</u> | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | | | | | | | |
| (b) <u>Pneumonia</u> | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| (c) <u>Lung Cancer</u> | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>JANUARY 10</u> , 19 <u>86</u> , to <u>JANUARY 11</u> , 19 <u>86</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>JANUARY 11</u> , 19 <u>86</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Valerie Barnwell</u> DEGREE | | | | | | | | | | | | | | | | 22c. DATE SIGNED <u>1/11/86</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Valerie Barnwell M.D.</u> | | | | | | | | | | | | | | | | 22e. ADDRESS <u>VAMC, Baltimore, Maryland 21218</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| Burial | | Jan. 14, 1986 | | GARRISON FOREST A. | | BALTIMORE | | Maryland | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| EVANGELICAL CHAPEL OF MEMORIES | | 8800 HARFORD ROAD | | JAN 16 1986 | | <u>John Davidson</u> | | | | | | | | | | | |

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FOR STATE REGISTRAR 2-3-84

REG. NO.

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| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | | | | | | | |
| BEATRICE | | E | | NEWMAN | | | | 1-19-86 | | | | | | | | 4:28 PM | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | | IF UNDER 1 YEAR | | | | IF UNDER 24 HRS. | | | | | | | |
| Female | | Black | | MONTH DAY YEAR 2 4 10 | | | | 75 YRS | | | | MONTHS DAYS HOURS MIN. | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | | | |
| Md. | | usa | | | | | | BALTIMORE City MD. | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| BALTIMORE | | North Charles General | | | | | | | | | | | | | | | | | | | | | |
| USUAL RESIDENCE IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION | | | | | | | | | | | | | | | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 21218 | | | | | | | | | |
| Md. | | | | | | | | Balto. | | | | | | 11 W 20th St. Apt. 1000-18 | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| Payton Johnson | | | | | | | | Nellie Travers | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | | | | | | | | | |
| | | | | | | | | 217-20-6919 | | | | Robert Barksdale 11W, 20th St. 21218 | | | | | | | | | | | |

| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|---|
| PART I. DEATH WAS CAUSED BY: | (a) <u>Pulmonary atelectasis, severe</u> | |
| IMMEDIATE CAUSE (a) | | |
| DUE TO, OR AS A CONSEQUENCE OF | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | (b) <u>Massive pulmonary embolism, bilateral</u> | |
| | DUE TO, OR AS A CONSEQUENCE OF | |
| | (c) | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Atherosclerotic heart disease - Gastric intestinal hemorrhage.

| 19a DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|-----------------------|--|--|---|
| | | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 19a | 19b | 20a | 20b |

| | | | | | | | | | | | | |
|--|---|-------|------|-------|-----|------|--|--|--|--|----|---|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;">HOUR</td> <td style="width: 15%;">A.M.</td> <td style="width: 15%;">MONTH</td> <td style="width: 15%;">DAY</td> <td style="width: 15%;">YEAR</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td>19</td> </tr> </table> | HOUR | A.M. | MONTH | DAY | YEAR | | | | | 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
| HOUR | A.M. | MONTH | DAY | YEAR | | | | | | | | |
| | | | | 19 | | | | | | | | |

| | | | | | | |
|-----------------|--|--|---------------|--------|--------------|--------|
| MEDICAL HISTORY | 21d. INJURY OCCURRED | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION | | | |
| | WHILE WORKING <input type="checkbox"/> NOT WHILE WORKING <input type="checkbox"/> WHILE DRIVING <input type="checkbox"/> WHILE WALKING <input type="checkbox"/> | | | STREET | CITY OR TOWN | COUNTY |

22a. I certify that (I) (this hospital) attended the deceased from 12/30/85, 1985, to 1/19/86, 1986, that (I) (we) lost
saw the deceased alive on 1/19/86, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) did (did not) view the body after death.

27b SIGNATURE *G. P. Pumper* DEGREE ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 27c DATE SIGNED 1/20/86

| | |
|---------------------------------------|-------------------------------------|
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
| IMPORN PREMPREE. | 2724 NORTON CHAS ST. BALI. MD 21218 |

| | | | | | |
|--|----------------------|---|---|---------------|-------|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 1/25/86 | 23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. | 23d. LOCATION CITY OR TOWN Westport | COUNTY Md. | STATE |
|--|----------------------|---|---|---------------|-------|

| | | |
|--|------------------------------|-------------------------------|
| 24 FUNERAL DIRECTOR | 25a DATE REC'D. BY REGISTRAR | 25b REGISTRAR'S SIGNATURE |
| NAME Gnas. Arice ESFA 1300 Eutaw PL | ADDRESS JAN 29 1986 | <i>Jake Burdson - Fordite</i> |

MEDICAL CERTIFICATION

9

BP_____

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

031151



20% COTTON FIBER

WASHING MACHINE

102180

102180

MEMBER

X

ORIGINAL

038051

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | REG. NO. | |
|--|--|--|---|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOSEPH NEWMAN | | 2a. DATE OF DEATH MONTH DAY YEAR 01-31-86 | | 2b. HOUR 1:10 AM |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR APR. 28, 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS. 81 YRS. MONTHS DAYS HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LEVINDALE HEBREW HOME | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PROPRIETOR | |
| 12b. KIND OF BUSINESS OR INDUSTRY BOWLING LANES | | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | 13b. CITY OR TOWN BALTIMORE | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13d. STREET ADDRESS / ZIP CODE 2907 FALLSTAFF RD. 21209 | | 14. FATHER'S NAME FIRST MIDDLE LAST HYMAN NEWMAN | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST REBECCA UNKNOWN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 215-22-3766 | | 17. INFORMANT MRS. ALMA MINKOVE 8247 BRATTLE RD. BALTO., MD 21208 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) ISCHEMIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 WK. YEARS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-15 , 19 86 , to 1-31 , 19 86 , that (I) (we) last saw the deceased alive on 1-31 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE B. ZAW-WIN, MD | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1-31-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. ZAW-WIN, MD | | 22e. ADDRESS LEVINDALE HEBREW HOME BALTO 21215 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE FEB. 2, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY MIKRO KODESH-BETH ISRAEL | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. NAME ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | 25. DATE RECD BY REGISTRAR FEB 03 1986 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

BP

035051

1955

NEWARK

01-21-86 1/2

Large the West End
Lithium heart stone

1-21-86
1-21-86

1-21-86 1-21-86 1-21-86

1-21-86 1-21-86 1-21-86
1-21-86 1-21-86 1-21-86

030032

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82
(VRA 15, 4)1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) Mildred E. Nicolai | | | 2a. DATE OF DEATH MONTH DAY YEAR 1/24/86 2b. HOUR 2:30 P.M. | | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 9, 1906 | 6. AGE (IN YEARS LAST BIRTHDAY) 79 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md. | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD | | |
| 10. CITY OR TOWN OF DEATH Dickeyville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2441 Pickwick Road | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | 12b. KIND OF BUSINESS OR INDUSTRY Homemaker | | |
| 13a. STATE Md. | | 13b. COUNTY --- | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 2441 Pickwick Road 21207 |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Ford Evans | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophia C. McNally | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-48-7091 | | 17. INFORMANT 10010 A-Castle Road - 23235. Evans Allen, ezger-Richmond, Va. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Green | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: --- | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 19 1983 to Jan 24 1986 , that (I) (we) last saw the deceased alive on Nov 18 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE William F. Fritz | | DEGREE MD | | 22c. DATE SIGNED 1/24/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) William F. Fritz, M. D. | | 22e. ADDRESS 2 W. University Parkway-Balto., Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/27/86 | 23c. NAME OF CEMETERY OR CREMATORY Western Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland |
| 24. FUNERAL DIRECTOR Sterling Funeral Estate, P.A. | | | 25a. DATE REC'D. BY REGISTRAR JAN 28 1986 | | |
| 25b. REGISTRAR'S SIGNATURE 736 Edmondson Ave.; Catonsville, Md. 21228. | | | | | |

MEDICAL CERTIFICATION

036041

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--------------------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| WALTER E. NIEDERWEMMER | | | | JANUARY 29. 1986 | | 9:30P M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | |
| Male | Cauc. | 05 25 1985 | | YRS. 8 | | MONTHS DAYS HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Maryland | U.S.A. | | | | BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BALTIMORE | THE JOHNS HOPKINS HOSPITAL | | | | | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE | | |
| MARYLAND | | | BALTIMORE | | 1229 TRAVERS WAY | | Baltimore, Md 21224 |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | |
| CHARLES L. SILVER | | PATRICIA H. NIEDERWEMMER | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| | | | | 1229 TRAVERS WAY PATRICIA H. NIEDERWEMMER - BALTIMORE, MD. 21204 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>DIFFUSE ANOXIC & ISCHEMIC INSURRY</u> | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARDIO PULMONARY ARREST</u> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>SUDDEN INFANT DEATH SYNDROME</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u></u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>MAY 25</u> , 19 <u>85</u> , to <u>JANUARY 29</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>JANUARY 29</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | 22c. DATE SIGNED | |
| <u>Thomas Adams Corson M.D.</u> | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | <u>January 29, 1986</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| THOMAS ADAMS CORSON, M.D. | | JOHNS HOPKINS HOSPITAL, BALTIMORE, MD. 21205 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| BURIAL | | 1/31/86 | | GARDENS OF FAITH | | BALTIMORE, MD. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | 25. DATE READY FOR BURIAL PART 25. REGISTRAR'S SIGNATURE | | | |
| Walter Dabrowski - 1005 Dundalk Ave. 21224 | | | | FEB 03 1986 <u>J. Davidson</u> | | | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician only, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2, and 3, and 4, and 5, and 6, and 7, and 8, and 9, and 10, and 11, and 12, and 13, and 14, and 15, and 16, and 17, and 18, and 19, and 20, and 21, and 22, and 23, and 24, and 25, and 26, and 27, and 28, and 29, and 30, and 31, and 32, and 33, and 34, and 35, and 36, and 37, and 38, and 39, and 40, and 41, and 42, and 43, and 44, and 45, and 46, and 47, and 48, and 49, and 50, and 51, and 52, and 53, and 54, and 55, and 56, and 57, and 58, and 59, and 60, and 61, and 62, and 63, and 64, and 65, and 66, and 67, and 68, and 69, and 70, and 71, and 72, and 73, and 74, and 75, and 76, and 77, and 78, and 79, and 80, and 81, and 82, and 83, and 84, and 85, and 86, and 87, and 88, and 89, and 90, and 91, and 92, and 93, and 94, and 95, and 96, and 97, and 98, and 99, and 100, and 101, and 102, and 103, and 104, and 105, and 106, and 107, and 108, and 109, and 110, and 111, and 112, and 113, and 114, and 115, and 116, and 117, and 118, and 119, and 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#1, per F.H. 2/25/86 kam

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

B 6 0 1 4 1 8

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) NOBLES, MALINDA A (Green) | | | 2a DATE OF DEATH MONTH DAY YEAR 1/31/86 | | | 2b HOUR 15:20 PM | | | |
| 3 SEX F | | 4 RACE B | | 5 DATE OF BIRTH MONTH DAY YEAR 2 14 47 | | 6 AGE (IN YEARS LAST BIRTHDAY) 38 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a BIRTHPLACE (COUNTRY) MD | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore, City MD | | | |
| 10 CITY OR TOWN OF DEATH BALTIMORE | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UMH | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OR WORKING LIFE) UNEMP | | 12b KIND OF BUSINESS OR INDUSTRY housewife | |
| 13a RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD COUNTY Baltimore CITY OR TOWN CITY | | | | 13b INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13c STREET ADDRESS / ZIP CODE 728 Connelley Rd 21215 | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Willie Green | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HATTIE L Thomas | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? YES NO OR UNKNOWN <input type="checkbox"/> (IF YES, GIVE WO OR DATES) | | | | 16b SOCIAL SECURITY NO. 218-48-17A | | 17 INFORMANT ADDRESS Hattie Marshall, 639 Leafydale Ter. 21208 | | | |

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 18 CAUSE OF DEATH Enter only one cause per line for 1a, 1b, and 1c. PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Collapse DUE TO, OR AS A CONSEQUENCE OF (b) Hemorrhagic Dysthesis DUE TO, OR AS A CONSEQUENCE OF (c) chronic liver Failure 2° Hepatitis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 1/2 yrs | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Intra-cerebral Hemorrhage | | | | | | | |
| 19a DATE OF OPERATION none | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11 86 1/31 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 1/31 86 to 1/31 86 that (I) (we) last saw the deceased alive on 1/31 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE Robert Burgerman MD DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c DATE SIGNED 1/31/86 | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Robert BURGERMAN | | | | 22e ADDRESS 22 So Green St Balto 21217 | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b DATE 2/5/86 | | 23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | |
| 24 FUNERAL DIRECTOR NAME Law Funeral Home 4611 Park Heights Ave. 21215 | | | | 25a DATE REC'D. BY REGISTRAR FEB 06 1986 | | | |
| | | | | 25b REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

12.24

11/11/80

VI: BEECH HAWKING

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X

WEST

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WINTER

WINTER

YOUNG CITY

WID

V

HATTI

11.11.80



Carbohydrate Cellulose

Hydrogen peroxide

Various other features

hydrogen peroxide

Crane

11.11.80

11.11.80

11.11.80

X

Robert (unclear)

Robert (unclear) 25.11.80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | |
|--|--|---|---|---|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) HERMAN NOONBERG | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 23, 1986 | | | 2b. HOUR 12:48 | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR MAR. 16, 1914 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 71 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN | | 12b. KIND OF BUSINESS OR INDUSTRY MD WHOLESALE & DRY GOODS | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | |
| 13a. STATE MARYLAND | | 13b. CITY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST AARON NOONBERG | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SOPHIA HONIGMAN | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. WWII-ARMY 216-10-2686 | | 17. INFORMANT MRS. EDITH NOONBERG 2523 SMITH AVE. BALTO., MD 21209 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hrs 4 hrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | | | |
| 19a. DATE OF OPERATION 1/22/86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Coronary Artery Disease | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO! WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/19/86</u> 19 <u>86</u> to <u>1/23</u> 19 <u>86</u> that (I) (we) last saw the deceased alive on <u>1/23</u> 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE <u>Peter J. Honigman</u> 22c. PHYSICIAN'S NAME (TYPE OR PRINT) PETER HONIGMAN | | | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22d. DATE SIGNED 1/23/86 | | |
| 22e. ADDRESS 600 N. WOLFE STREET BALTO MD. JOHNS HOPKINS HOSPITAL | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE JAN. 24, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY CHIZUK AMUNO (ARLINGTON) | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | | |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD., BALTO., MD 21215 | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 29 1986 <u>John W. Henderson-Randall</u> | | | | |

MEDICAL CERTIFICATION

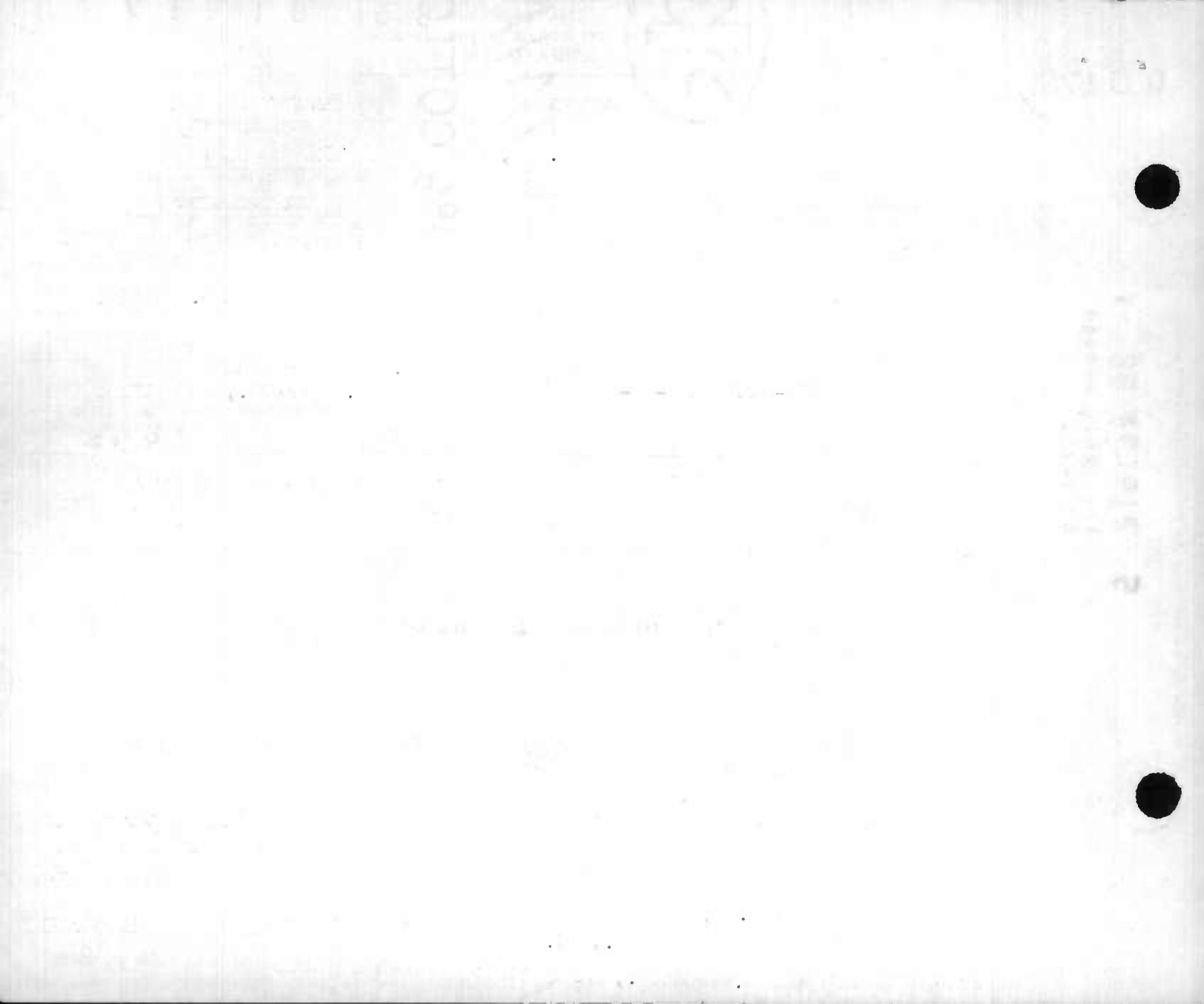
BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please deliver your copy of pages 3 and 4 to the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposal.

IMPORTANT: If item 21 is marked or item 18 is not as any injury, or other traumatic event, the medical examiner must be notified.

031175



STATE OF MARYLAND 8 6
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

01420

0370130

| | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|--------------------------------|--|------------------|--|
| FOR 1- STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| | | Juanita M. O'Brien | | | | 1/29/86 | | 8:15 A.M. | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Female | | White | | MONTH DAY YEAR 9 26 26 | | 59 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Washington, D.C. | | U.S.A. | | | | Baltimore City | | | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Baltimore | | S. Baltimore General Hosp. | | Draftsman | | Gov't. Contractor | | | | | |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | |
| Md. | | Pr. Geo. | | W. Hyattsville | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 6624 24th Place | | 20782 | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | |
| Guy P. Murray | | Marie C. Federlin | | 579260896 | | Daughter | | 9110 Winding Way | | | |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 18b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | 9110 Winding Way | | | |
| No | | 579260896 | | Carol O'Brien | | Ellicott City, Md. | | 21043 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) <u>9 of lung, brain, & bone</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) _____ | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/24/86</u> , 19 <u>86</u> , to <u>1/29/86</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>1/29/86</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | | | | | |
| Gary R. Burman, M.D. | | | | | | 1/29/86 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | |
| Gary R. Burman | | South Baltimore General Hospital | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | Feb. 1 1986 | | St. John's Cemetery | | Forest Glen Montgomery Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Francis J. Collins, Jr. 500 University Blvd., W. Silver Spring, Md. | | FEB 04 1986 | | John Davidson-Randall | | | | | | | |

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11/20/60

South California Branch, Houston

FEB 04 1961

016090

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Emma M. O'Connor | | | 2a. DATE OF DEATH MONTH DAY YEAR January 8, 1986 | | | 2b. HOUR 6:45 AM | | | |
| 3 SEX Female | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR Nov. 24, 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10 CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 223 E. Northern Parkway, Apt. E | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY 13c. CITY OR TOWN Baltimore 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE 223 E. Northern Pkwy. Apt. E 21212 | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Antone Heil | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Issette | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-12-4977 A | | 17. INFORMANT ADDRESS Doris E. Nechamkin - Same as #13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF: b) <u>A-3. CVD</u> DUE TO, OR AS A CONSEQUENCE OF: c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>10 yrs</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a) <u>Hypertension</u> | | | | | | | | | |
| 19a. DATE OF OPERATION <u>11/5/85</u> | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u></u> | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/5/85</u> to <u>1/8/86</u> , that (I) <u>last</u> saw the deceased alive on <u>5/30/85</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (If <u>not</u> <u>not</u> view the body after death.) | | | | | | | | | |
| 22b. SIGNATURE <u>Norman R. Freeman</u> | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED <u>1/8/86</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Norman Freeman M.D. | | | | 22e. ADDRESS 4300 North Charles St., Baltimore, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-10-86 | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood | | 23d. LOCATION CITY OR TOWN COUNTY STATE Parkville, Balto., Md. | | | |
| 24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Md. 21204 | | | | 24. FUNERAL DIRECTOR ADDRESS 1050 York Rd. | | 25a. DATE REC'D. BY REGISTRAR JAN 13 1986 | | | |
| 25b. REGISTRAR'S SIGNATURE <u>James H. Anderson-Randall</u> | | | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical record should be notified at once.

V



Handwritten text, possibly a signature or name, appearing as "A. J. ...".

Handwritten text, possibly a date or reference number, appearing as "1/2/50" and "X".

029084

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD., 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 01422 | |
|---|----------------------|---|---|--|---|--|--|---|--|----------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) Michael Raymond O'Donnell, Jr. | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 1 22 19 86 | | 7b. HOUR M | | | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 12 19 70 | 6. AGE (IN YEARS) LAST BIRTHDAY 15 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD 1 22 19 86 | | 7d. HOUR 7:40P | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Connecticut | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student | | 12b. KIND OF BUSINESS OR INDUSTRY -- | | | | |
| 13a. STATE Virginia | | 13b. COUNTY North Virginia | | 13c. CITY OR TOWN North Virginia | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS North Virginia P.O. Box 71 23128 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Michael R. O'Donnell, Sr. | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vickie Hicks | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 048-66-4747 | | 17. INFORMANT ADDRESS Joe Goenes Box 71 North Virginia 23128 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8120 IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR MONTH DAY YEAR 3:39 P.M. 1 22 19 86 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver in tractor truck/tractor truck impact | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE I-95 nr. Frenchtown Rd, Perryville, Cecil, MD. | | | | | | |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Margaret McKee | | | TITLE (SPECIFY) M.D. Assistant | | | MEDICAL EXAMINER | | DATE SIGNED 1/23/86 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | | ADDRESS 111 Penn St. Balto. MD. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1/26/86 | | 23c. NAME OF CEMETERY OR CREMATORY Heritage Memorial Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Dutton Mathews VA. | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229 | | | 25a. DATE REC'D. BY REGISTRAR JAN 27 1986 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | | |

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(VR A15 ME (5))

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2010 OCTOBER 188030

CHINESE NEW YORK

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

028115

FOR
STATE
REGISTRAR

| | | | | | |
|---|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Virginia D. OGLE | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 22, 1986 | | 2b. HOUR 5:20 P.M. |
| 3. SEX FEMALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR AUG. 6, 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 615 EAST 35 TH STREET | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AT HOME | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE MARYLAND | 13b. COUNTY | 13c. CITY OR TOWN BALTIMORE | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 615 EAST 35 TH STREET 21218 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH FORDYCE | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST REBECCA J. RHOADS | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215 03 1978 | 17. INFORMANT ADDRESS FAMILY RECORDS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Adenocarcinoma (Widespread) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Adenocarcinoma of Cecum DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6-8 months 10-12 months | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 11c | | | | | |
| 19a. DATE OF OPERATION 9-3-85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Adenocarcinoma of Cecum - Ovary. | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-23, 1985, to 1-22, 1986, that (I) (we) lost saw the deceased alive on 11-15, 1985, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Theodore E Evans | | DEGREE MD | | 22c. DATE SIGNED 1-23-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) THEODORE E EVANS MD | | 22e. ADDRESS 9660 BELAIR RD BALTO MD 21236 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE JAN. 25, 1986 | 23c. NAME OF CEMETERY OR CREMATORY DRUID RIDGE | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | |
| 24. FUNERAL DIRECTOR NAME EVANS CHAPEL OF MEMORIES HARFORD RO. | | ADDRESS 8800 | | 25a. DATE REC'D. BY REGISTRAR JAN 24 1986 | 25b. REGISTRAR'S SIGNATURE MURDERMAN |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.



027086

#7A Per F.H. 1/28/86 Km

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 1 4 2 4

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | | | |
|--|--|------------------|---|---|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) SYLVIA J. OLIVER | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 21 86 | | | 2b. HOUR 6:20 P.M. | | | | | | | |
| 3. SEX F | | 4. RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR 12 25 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS. HOURS MIN. | | | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA. MD | | | 9b. CITIZEN OF WHAT COUNTRY? USA | | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Maryland Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE 11 W. 20th St Apt 10 G 21218 | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Andrew Coleman | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Betty Dishmond | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 218 039456 | | | 17. INFORMANT ADDRESS Joan Wilson 1111 Stamford Road | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) End stage renal failure. DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) S/p cerebrovascular accident. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: S/p cerebrovascular accident. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months. | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M. | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/19 19 85 to 1/21 19 86 that (I) (we) last saw the deceased alive on 1/21 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (we) did not view the body after death. | | | | | | | | | | | | | |
| 22a. SIGNATURE A. Conjura DEGREE | | | | | | 22b. DATE SIGNED 1/21/86 | | | | | | | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT) A. CONJURA | | | | | | 22d. ADDRESS U. of Md. Hospital, Greene St., Baltimore | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1/27/86 | | | 23c. NAME OF CEMETERY OR CREMATORY Westview Memorial Park | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Md | | | | |
| 24. FUNERAL DIRECTOR NAME William C. March F/H ADDRESS West 4300 Wabash Avenue | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 23 1986 | | | 25b. REGISTRAR'S SIGNATURE John Davidson-Randall | | | | |

MEDICAL CERTIFICATION

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 7 and 8 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Sara Lou OLSON | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 13 1986 | | 2b. HOUR 8:30 A.M. |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 3 14 27 | 6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ILLINOIS | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Maryland Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY CARROLL 13c. CITY OR TOWN Westminster | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WALTER McDONALD | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GRACE WATTS | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) na | 17. INFORMANT ADDRESS Gordon Olson 67 W. Green Street Westminster, MD. 21157 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Breast Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hours 7 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/25/86, 19, to 1/13, 19, 86, that (I) (we) last saw the deceased alive on 1/13, 19, 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE William Tan | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/13/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM TAN | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/16/86 | 23c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial | | 23d. LOCATION CITY OR TOWN COUNTY STATE Finksburg Carroll MD |
| 24. FUNERAL DIRECTOR NAME Robert K. Pritts, Sr., ADDRESS Westminster, MD | | | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

B

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

COMMUNICATIONS SECTION
U.S. AIR FORCE
HONOLULU, HAWAII



030097

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|--|--|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) <i>O'Neil; Marie, Margaret Alice</i> | | | 2a DATE OF DEATH MONTH DAY YEAR <i>1/25/86</i> | | 2b HOUR <i>925 AM</i> |
| 3 SEX <i>Female</i> | 4 RACE <i>White</i> | 5 DATE OF BIRTH MONTH DAY YEAR <i>5 16 01</i> | 6 AGE (IN YEARS LAST BIRTHDAY) <i>84</i> YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Gallitzier Pa.</i> | 7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD. | | |
| 10 CITY OR TOWN OF DEATH <i>Baltimore</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Perring Parkway Nursing Home</i> | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Home Maker</i> | | 12b KIND OF BUSINESS OR INDUSTRY |
| 13a STATE <i>Md.</i> | 13b COUNTY | 13c CITY OR TOWN <i>Balto.</i> | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS / ZIP CODE <i>5470 Cedonia Ave. -21206</i> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST <i>John Becker</i> | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Kilduff</i> | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NAME OR UNKNOWN) <i>No</i> | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>218-54-3775</i> <i>215-10-37390</i> | 17 INFORMANT ADDRESS <i>Patricia M. Redmond 5470 Cedonia Ave. -21206</i> | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIAC ARREST</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>MYO CARDIAC VASCULAR DIS.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>H. A. SCUD.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11/25/85</i> to <i>1/25/86</i> that (I) (we) last saw the deceased alive on <i>1/25/86</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>Anthony F. Carozzi MD.</i> | | DEGREE <i>MD.</i> | | 22c. DATE SIGNED <i>1/25/86</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Anthony F. Carozzi MD.</i> | | 22e. ADDRESS <i>4214 MARANWOOD DR. GLEN ARDEN 21057.</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | 23b. DATE <i>1-18-86</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cem</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto. Md.</i> | |
| 24 FUNERAL DIRECTOR NAME ADDRESS <i>John C. Miller Inc-6415 Belair Rd. -21206</i> | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>JAN 28 1986</i> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

West Africa

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023022

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--------|--|--------------------------------|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1 DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | MONTH DAY YEAR | |
| JOHN Joseph OSWINKLE | | January 20, 1986 | | 1:30 PM | |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH | 6 AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| Male | White | 7 MONTH DAY YEAR | 67 | IF UNDER 24 HRS | |
| 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | MONTHS DAYS HOURS MIN. | |
| U.S.A. | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | YRS. | |
| 9 BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | MD. | |
| Maryland | | Baltimore City | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUBCITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) | |
| Baltimore | | Church Hospital | | Retired | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | |
| Martin-Marietta | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1104 Broening Highway 21224 | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| Maryland | | Baltimore | | Baltimore | |
| 14 FATHER'S NAME | | 15 MOTHER'S MAIDEN NAME | | | |
| First MIDDLE LAST | | First MIDDLE LAST | | | |
| Joseph Oswinkle | | Barbara Horst | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 216-03-1536 | | Anna M. Oswinkle 1104 Broening Hwy. 21224 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) Cancer Kidney with Metastasis | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (b) | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| Urinary Tract Infection High Blood Pressure | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from January 14, 1986, to January 20, 1986, that (I) (we) last saw the deceased alive on January 20, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| A.F. Nazemi M.D. | | | | 1/20/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| A.F. Nazemi M.D. | | Church Hospital | | | |
| | | 100 North Broadway Baltimore, Md 21231 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 1-24-86 | | Oak Lawn Cemetery | |
| | | | | Eastwood, Balto Co., Md. | |
| 24 FUNERAL DIRECTOR | | 25. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| NAME ADDRESS | | JAN 21 1986 | | Julia Davidson-Randall | |
| Charles S. Zeiler & Son Inc. | | | | | |
| 8224 Eastern Ave. | | | | | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked on item 18 above, any injury, or other traumatic event, the medical examiner must be called to give.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, entombment or removal.

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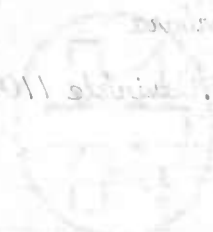
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

Adalbert (NMN) Ott

| | | | | | | | |
|---|--|--|--|---|------------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ADALBERT OTT | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 7 86 | | 2b. HOUR 7:10 A.M. | | |
| 3. SEX Male | | 4. RACE Cauc. | | 5. DATE OF BIRTH MONTH DAY YEAR 4/23/05 | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Resita, Romania | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Butcher | | 12b. KIND OF BUSINESS OR INDUSTRY GOETZ MEATS | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Gyula Ott | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Baumann | | 16. STREET ADDRESS / ZIP CODE 4314 Seidel Avenue 21206 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 172-26-2534 | | 17. INFORMANT ADDRESS Joseph R. Ott, same address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Septicemia | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Infected skin decubiti | | | | | | years | |
| DUE TO, OR AS A CONSEQUENCE OF (c) chronic urinary retention | | | | | | years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Chronic obstructive pulmonary disease | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11 10 1986 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/6 , 19 86 , to 1/7 , 19 86 , that (I) (we) last saw the deceased alive on 1/7 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Evan J. Seldy MD | | | | DEGREE MD | | 22c. DATE SIGNED 1/7/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Evan J. Seldy MD | | | | 22e. ADDRESS Mercy Hospital 301 St. Paul Place Balto., Md 21202 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/10/86 | | 23c. NAME OF CEMETERY OR CREMATORY Holly Hill | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md. | |
| 24. FUNERAL HOME NAME ADDRESS Schimmek Funeral Home, Inc. 3331 Brehms Lane Balto., Md. 21213 | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 10 1986 | | | |

MEDICAL CERTIFICATION

BP

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014129

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | |
|---|--|--|--|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) Willard E Otto, Sr | | | 2a DATE OF DEATH MONTH DAY YEAR 1 8 86 | | 2b HOUR 3:30 P M |
| 3 SEX MALE | 4 RACE WHITE | 5 DATE OF BIRTH MONTH DAY YEAR NOV. 15 1915 | 6 AGE (IN YEARS LAST BIRTHDAY) 70 YRS | 7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 8 BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | 9b CITIZEN OF WHAT COUNTRY? USA | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 10 CITY OR TOWN OF DEATH MD. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANCIS SCOTT KEY MED. CEN. | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STEEL WORKER | 12b KIND OF BUSINESS OR INDUSTRY ARMCO | |
| 13a. STATE MD. | | | 13b. CITY OR TOWN BALTIMORE | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 3549 JUNEWAY 21213 |
| 14 FATHER'S NAME FIRST MIDDLE LAST SAMUEL LEE OTTO | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMA CAMP | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-18-8310 | 17. INFORMANT ADDRESS WILLARD OTTO JR. (SON) 2919 VAILTHORN RD. 21220 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | |
| 19a DATE OF OPERATION | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22 I certify that (I) (this hospital) attended the deceased from 1/7, 19 86, to 1/8, 19 86, that (I) (we) last saw the deceased alive on 1/8, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 27b SIGNATURE Regina J. Healy | | DEGREE | 27c DATE SIGNED 1/8/86 | | |
| 27d PHYSICIAN'S NAME (TYPE OR PRINT) Healy | | 27e ADDRESS FSKMC 4900 Eastern Ave Balt MD | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b DATE 1/11/86 | 23c NAME OF CEMETERY OR CREMATORY Crestlawn | 23d LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | | |
| 24 FUNERAL DIRECTOR NAME Schimunek Funeral Home, Inc. 3331 Brehms Lane, Balto. Md. 21213 | | 25a DATE REC'D. BY REGISTRAR JAN 10 1986 | 25b REGISTRAR'S SIGNATURE | | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove it from the bottom of pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

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UNITED STATES DEPARTMENT OF THE ARMY
HEADQUARTERS, ARMY
WASHINGTON, D. C.



X

FOR OFFICIAL USE ONLY

024074

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

01430

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|--|--|---|---|--|----------------------------------|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) VIOLA OWENS | | | 2a. DATE OF DEATH MONTH DAY YEAR 1-19-86 | | 2b. HOUR MIN 1:27 P | | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 5/13/1911 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS 74 | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Philip Updenwood | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Updenwood | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 214-24-3116 | |
| 17. INFORMANT ADDRESS 1558 Nicholas 21214 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) STATUS POST CEREBRO-VASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF (c) RULE OUT ACUTE MYOCARDIAL INFARCTION | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (1) SEPSIS (2) HYPERTENSION (3) SEIZURE DISORDER | | | | | | | |
| 19a. DATE OF OPERATION 1-15-86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED RESPIRATORY FAILURE | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-9-85 to 1-19-86 , that (I) (we) lost saw the deceased alive on 1-19-86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Anil N. Raiker | | DEGREE MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1-19-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANIL N. RAIKER | | 22e. ADDRESS LUTHERAN HOSPITAL | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (BY WHOM) Burial | | 23b. DATE 1/25/86 | | 23c. NAME OF CEMETERY OR CREMATORY Viola Memorial | | 23d. LOCATION CITY OR TOWN STATE Baltimore, Md. | |
| 24. FUNERAL DIRECTOR (NAME) Cunill | | 24b. ADDRESS 1712 W. North Ave | | 25a. DATE RECEIVED BY REGISTRAR JAN 22 1986 | | | |

MEDICAL CERTIFICATION

99

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be signed by a physician.

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000 15 AM

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH**

REG. NO.

| | | | | | | |
|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) ROBERT PACE | | | 2a. DATE OF DEATH MONTH DAY YEAR JAN. 10, 1986 | | 2b. HOUR 7:14 ^A _M | |
| 3 SEX M | | 4. RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR 5 19 07 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 72 HRS: HOURS MIN. | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE MARYLAND | | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WELDON PACE | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST WILLIE HOWARD | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) UNKNOWN | | 17. INFORMANT ADDRESS BOBBIE MANGUM 2037 SINCLAIR LANE | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) INTRACEREBRAL BLEED DUE TO, OR AS A CONSEQUENCE OF (c) CEREBROVASCULAR DISEASE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hours 2 yrs. | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan. 9, 1986 to Jan 10, 1986 , that (I) (we) last saw the deceased alive on Jan. 10, 1986 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE <i>Eric Brown</i> | | | | 22c. DATE SIGNED 1/10/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eric Brown MD | | | | 22e. ADDRESS 600 N. WOLFE ST. BALTO MD. 21205 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 1-14-86 | | 23c. NAME OF CEMETERY OR CREMATORY MARYLAND NATIONAL | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS WM. C. MARCH F/H INC. 1101 E. NORTH AVE. | | 23d. LOCATION CITY OR TOWN COUNTY STATE LAUREL MARYLAND | | | | |
| 25a. DATE REC'D. BY REGISTRAR JAN 13 1986 | | | | 25b. REGISTRAR'S SIGNATURE <i>John Davis</i> | | |

MEDICAL CERTIFICATION

2

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned to the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|---|---|--|--|-----------------------------------|--|-----------------|------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR |
| Meredith | | | CLAYTON | Page | 1 | 19 | 86 | | 8:00 AM |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | |
| MALE | WHITE | 1 MONTH DAY 13 1913 | | 73 | MONTHS DAYS | | HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| MARYLAND | U.S.A. | | | BALTIMORE CITY | | MD. | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| BALTIMORE | ST. AGNES HOSPITAL | | SALESMAN | | DAIRY | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 300 Westshire Rd. 21229 | | | | | |
| MARYLAND | | Baltimore | Baltimore | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | | | | | |
| Walter D. Page | | Edna Hood | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| No | | 212-05-3783 | | Mrs. Ruth W. Page - Same as Sec. 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | |
| (b) _____ | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) _____ | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>19 Jan</u> 19 <u>86</u> , to <u>19 Jan</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>19 Jan</u> 19 <u>86</u> (and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED | |
| <u>David A. Jung</u> | | | | | | | | 1/19/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | |
| DAVID A. JUNG M.D. | | St. Agnes Hospital, Baltimore Maryland | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Cremation | | 1-20-1986 | | Westview Crematory | | Catonsville Balto. MD. | | | |
| 24a. FUNERAL DIRECTOR'S NAME | | 24b. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Leroy M. & Russell C. Witzke Funeral Homes P.A. | | 1630 Edmondson Ave., Catonsville, MD. 21228 | | JAN 21 1986 | | | | | |

MEDICAL CERTIFICATION

29

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

01433

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|---------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| clardella | | Palmer | | 1 | | 13 | | 86 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| FEMALE | | BLACK | | MONTH DAY YEAR | | 74 | | MONTHS DAYS HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| MARYLAND | | U.S.A. | | | | BALTIMORE | | City | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| BALTIMORE | | Deaton Hospital + medical center | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | |
| MARYLAND | | A.A. | | ANNAPOLIS | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 14 Fleet Street 21401 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| MOSES | | SMITH | | NO | | | | SARAH A. HAMMOND Annapolis, Md. 21401 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Sepsis | | DUE TO, OR AS A CONSEQUENCE OF (b) Infected decubiti | | DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | weeks | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | weeks | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: multiple CVA's | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/16/86 to 1/13/86, that (we) last saw the deceased alive on 1/13/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE J. Gladue, MD | | DEGREE | | 22c. DATE SIGNED 1/13/86 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | |
| | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| BURIAL | | 1-18-1986 | | BREWER HILL CEMETERY | | Annapolis, A.A. Maryland | | | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| WILLIAM REESE & SONS MORTUARY, P.A. | | JAN 16 1986 | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]
RE: [Illegible]

[Large block of illegible text, possibly a memorandum or report body]

Very truly yours,
[Illegible Signature]
Special Agent in Charge

023038

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) Mr. Frank John Palumbo | | 2a. DATE OF DEATH MONTH <u>1</u> YEAR <u>1986</u> January 17 1986 | | 2b. HOUR 8:30 P | |
| 3. SEX Male | 4. RACE Caucasian | 5. DATE OF BIRTH MONTH <u>6</u> DAY <u>15</u> YEAR <u>1904</u> June 15 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS | IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | 7b. CITIZEN OF WHAT COUNTRY? United States | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Gas Station Att | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 3023 W. Belvedere Avenue 21215 |
| 14. FATHER'S NAME FIRST Felix Palumbo MIDDLE Felix LAST PALUMBO | | 15. MOTHER'S MAIDEN NAME FIRST Angelina MIDDLE Cremona LAST CREMONA | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 215-01-7123 | | 17. ADDRESS Mr. Frank Palumbo 21227 287 Keeton Road Elkridge Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) SEPSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) PNEUMONIA | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) LEG CARCINOMA | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/10</u> 19 <u>86</u> , to <u>1/17</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>1/17</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE L. Llewellyn Kitchen MD | | DEGREE | | 22c. DATE SIGNED 1/17/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) LLEWELLYN KITCHEN | | 22e. ADDRESS UNION MEMORIAL HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-21-86 | | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery | |
| 23d. LOCATION CITY OR TOWN Baltimore | | COUNTY Maryland | | STATE | |
| 24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc. ADDRESS 8728 Liberty Road Randallstown, Maryland 21133 | | | | 25a. DATE REC'D. BY REGISTRAR JAN 21 1986 | |
| | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

023023



RECEIVED

CHIEF OF POLICE

Mr. J. Edgar Hoover
Washington, D.C.
Dear Sir:
Enclosed for you are two copies of a letterhead memorandum dated and captioned as above.
Very truly yours,
J. Lee Rankin
Chief of Police

Enclosure
J. Lee Rankin
Chief of Police
Washington, D.C.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 1 4 3 5

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Mary Parker (Jefferson) | | 2a. DATE OF DEATH MONTH DAY YEAR 1-19 -86 | | 7b. HOUR M | |
| 3. SEX FEMALE | | 4. RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR 5 24 1929 | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH City | | 10. CITY OR TOWN OF DEATH Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 125 N. Fulton Avenue | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | 13a. STREET ADDRESS / ZIP CODE 125 N. Fulton Ave. 21223 | |
| 13a. STATE Md. | | 13b. COUNTY | | 13c. CITY OR TOWN Balto. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Albert Parker | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Roberta Flowers | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | |
| 16b. SOCIAL SECURITY NO. 220 20 1582 | | 17. INFORMANT ADDRESS Charles Jefferson 125 N. Fulton | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metabolic abnormalities (acidosis, renal failure, hyperkalemia)</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Advanced Head and Neck Squamous Cancer</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) did not view the body after death. | | | | | |
| 22b. SIGNATURE <i>[Signature]</i> | | DEGREE MD | | 22c. DATE SIGNED 1/20/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) PARNES | | 22e. ADDRESS 22 S Greene St Balto. Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/23/86 | | 23c. NAME OF CEMETERY OR CREMATORY Arbutus | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md. | | 24. FUNERAL DIRECTOR NAME James A. Morton & Sons | | 25a. DATE REC'D. BY REGISTRAR JAN 21 1986 | |
| 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

030000



2011
2011

01-1074

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|--|--|---|---|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) QUINCY WOODROW PARKER | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 7 86 | | | 2b. HOUR 7:50AM | | | |
| 3. SEX M | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR 10 5 14 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE VA MEDICAL CENTER | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter | | 12b. KIND OF BUSINESS OR INDUSTRY Local #1 | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE MD | | 13b. COUNTY BALT | | 13c. CITY OR TOWN BALT | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 102 N PACA ST / 21201 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Harrison Parker | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude Parker | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) WW 11 | | 17. INFORMANT ADDRESS 21218 Shirley Parker 332 Ilchester Avenue | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>LEFT LUNG PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 MINUTES GREATER THAN 7 DAYS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CACHEXIA, WEIGHT LOSS</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>January 6, 19 86</u> , to <u>January 6, 19 86</u> , that (I) (we) last saw the deceased alive on <u>January 6, 19 86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Peter H Gorman MD</u> | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/7/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) PETER H GORMAN, MD | | | | | | 22e. ADDRESS 3900 Loch Raven Blvd. Baltimore MD 21218 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | 23b. DATE 1-8-86 | | 23c. NAME OF CEMETERY OR CREMATORY Security Process | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | | |
| 24. FUNERAL DIRECTOR NAME Cremation Society of Md. Inc. Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 10 1986 | | | |
| 25b. REGISTRAR'S SIGNATURE <u>Julia Swickard-Randall</u> | | | | | | | | | |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return the completed page 3 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked by item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

020051

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <i>Selma</i> | | 3. SEX FEMALE | | 4. RACE BLACK | | 5. DATE OF BIRTH 7 MONTH 7 DAY 48 ^R | | 2a. DATE OF DEATH MONTH DAY YEAR 1-12-86 | | 2b. HOUR 2:05 ^P _M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE | | | | MD. | |
| 10. CITY OR TOWN OF DEATH BLATIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LUTHERN HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 917 Franklinton Rd. 21216 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST RUFUS McLaughlin | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MILDRED PRATT | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 219-52-7556 | | 17. INFORMANT Baltimore, Md. 21216 | | 17. INFORMANT MILDRED McLAUGHLIN 917 N. Franklinton Rd. | |

| | | | |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Cardiogenic shock. | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | |

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Respiratory failure - Cardiac arrhythmias | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-4 19 86 to 1-12 19 86 , that (I) (we) last saw the deceased alive on 1-12 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE BICH T DUONG | | | | DEGREE MD | | 22c. DATE SIGNED 1-12-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BICH T DUONG | | | | 22e. ADDRESS LUTHERAN HOSPITAL | | | |

| | | | | | | | |
|--|--|-------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL BURIAL | | 23b. DATE 1-17-1985 | | 23c. NAME OF CEMETERY OR CREMATORY MOSES CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE Drury A.A. Maryland | |
| 24. FUNERAL DIRECTOR NAME ADDRESS WILLIAM REESE & SONS MORTUARY, P.A. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 18 1986 | | 25b. REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

219

BP

2017 年 12 月 1 日

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010023

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | |
|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) VIOLA M. PARKER | | 2a. DATE OF DEATH MONTH 01 DAY 04 YEAR 86 | | 2b. HOUR 12³⁴ AM | |
| 3. SEX FEMALE | | 4. RACE CAUC. | | 5. DATE OF BIRTH MONTH 01 DAY 01 YEAR 01 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical Center | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Dundalk | |
| 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 7512 Carroll Avenue | | 21222 | |
| 14. FATHER'S NAME FIRST Charles MIDDLE Anderson LAST Anderson | | 15. MOTHER'S MAIDEN NAME FIRST Alice MIDDLE Maher LAST Maher | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 215-01-0036 | | 17. INFORMANT Louise House | |
| 16c. ADDRESS Same as 13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY EDEMA DUE TO, OR AS A CONSEQUENCE OF (c) AORTIC STENOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. SIGNATURE Christine C. Harter MD | | 22b. DEGREE MD | |
| 22c. DATE SIGNED 1/4/86 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. HARTER | | 22e. ADDRESS 4940 EASTERN AVE BALT, MD 21224 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/7/1986 | | 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | 23e. DATE REC'D. BY REGISTRAR | | 23f. REGISTRAR'S SIGNATURE | |
| 24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue Dundalk, Maryland 21222 | | | | | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove and complete page 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

01439

| | | | | | | | | | | | |
|--|---------|--|-------------------|--|---------------------|---|--|-----------------------------------|--|-----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE KNOWN OF DEATH | | | | 2b. HOUR | | | |
| William T. Parker | | | | ESTIMATED XX 1-5 19 86 | | | | a. M | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR. | 8. IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD | | | | 2d. HOUR | |
| Male | Black | 6- 16- 20 | 65 YRS. | | | 1-6 19 86 | | | | 7:25 a. M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Virginia | | U. S. A. | | | | Baltimore City, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | 2802 Winchester Street | | | | Laborer | | | | | |
| 13a. STATE | | | | | | | | | | | |
| Maryland | | | | | | | | | | | |
| 13b. COUNTY | | | | | | | | | | | |
| Baltimore | | | | | | | | | | | |
| 13c. CITY OR TOWN | | | | | | | | | | | |
| Baltimore | | | | | | | | | | | |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 13e. STREET ADDRESS | | | | | | | | | | | |
| 2802 Winchester St. 21216 | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | | | | | | |
| Leroy Parker | | | | | | | | | | | |
| 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| Minnie Harmon | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | | | | | | | | |
| Yes | | | | | | | | | | | |
| (IF YES, GIVE WAR OR DATES) | | | | | | | | | | | |
| WW II | | | | | | | | | | | |
| 16b. SOCIAL SECURITY NO. | | | | | | | | | | | |
| 223-16-3762 | | | | | | | | | | | |
| 17. INFORMANT | | | | | | | | | | | |
| Sheila Pritchett 2802 Winchester St. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | |
| P.M. 19 | | | | | | | | | | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | | | | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | | | | | | |
| 21f. LOCATION | | | | | | | | | | | |
| CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | | | | | | | | |
| Dennis F. Smyth, M.D. | | | | | | | | | | | |
| TITLE (SPECIFY) | | | | | | | | | | | |
| M.D. Assistant MEDICAL EXAMINER | | | | | | | | | | | |
| DATE SIGNED | | | | | | | | | | | |
| 1-6-86 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | | | | | | | | |
| Dennis F. Smyth, M.D. | | | | | | | | | | | |
| ADDRESS | | | | | | | | | | | |
| 111 Penn St., Balto., Md. 21201 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | | | | | | | |
| Burial | | | | | | | | | | | |
| 23b. DATE | | | | | | | | | | | |
| 1-9-86 | | | | | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | | |
| Garrison Forest Cemetery | | | | | | | | | | | |
| 23d. LOCATION | | | | | | | | | | | |
| OWINGS MILLS, MD | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | | |
| NAME ADDRESS | | | | | | | | | | | |
| Bailey-Douglass Funeral Home 1348 N. Calhoun St. | | | | | | | | | | | |
| 25a. DATE REC'D. BY REGISTRAR | | | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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FOR
STATE
REGISTRAR

Item 1 G 613 3/21/86 cw

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) Alfonso Alphonso Parks | | | 2a. DATE OF DEATH MONTH DAY YEAR January 27, 1986 | | | 2b. HOUR 12:10A | | | |
| 3. SEX male | | 4. RACE black | | 5. DATE OF BIRTH MONTH DAY YEAR 10 2 24 | | 6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 61 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) COUNTY N.C. | | 7b. CITIZEN OF WHAT COUNTRY? U S A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY Post Office | |
| 13a. STATE Md | | | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Gallaway Parks | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada Wooten | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII | | 17. INFORMANT ADDRESS Hazel Parks 1402 N. Rosedale Street | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hyperkalemia | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Unknown |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Renal Failure | | | | | | | | | Three Years |
| (c) Hypertension | | | | | | | | | Sixteen years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Congestive Heart Failure | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from January 8 , 19 86 , to January 27 , 19 86 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on January 27 , 19 86 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Chuh-Chin Huang</i> | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/27/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Muh-Chin Huang, M.D. | | | | | | 22e. ADDRESS c/o Maryland General Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1/31/86 | | 23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Vet | | 23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills MD | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS William C. March F/H West 4300 Wabash Avenue | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 28 1986 | | 25b. REGISTRAR'S SIGNATURE <i>James M. Rendon</i> | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the office.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove, correct, reinsert, or remove, as necessary, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | MONTHS DAYS HOURS MIN. | |
| FLORENCE | | JANUARY 15, 1986 | | 6:00 A M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| FEMALE | BLACK | MONTH DAY YEAR | | 7. IF UNDER 1 YEAR | |
| | | NOV. 29, 1921 | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| KENTUCKY | USA | | | BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| BALTIMORE | THE JOHNS HOPKINS HOSPITAL | | MANAGER | | US GOV'T |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. STREET ADDRESS / ZIP CODE | |
| MD | MONTG. | DERWOOD | INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | 10 OSKALOOSA CT.? 20855 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. SOCIAL SECURITY NO. | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | 17. INFORMANT ADDRESS | |
| WOODSON HARPER | | UNKNOWN | | HENRY W. PASH (SON) SAME AS #13 | |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) | | 18b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | | | HENRY W. PASH (SON) SAME AS #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> | | | | | 5 minutes |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hepatic and Renal Failure</u> | | | | | 2 weeks |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Colon CANCER, metastatic to Liver</u> | | | | | 8 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | HOUR A.M. MONTH DAY YEAR | | | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/11</u> 19 <u>86</u> to <u>1/15</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>1/15</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| <u>Daniel L. Clemens</u> | | MD | | 1/15/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| Daniel L. Clemens, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| REMOVAL | | 1-16-86 | | A.D. Porter Fun. Home | |
| | | | | Louisville, Kentucky | |
| 24. FUNERAL DIRECTOR | | 24b. DATE REC'D. BY REGISTRAR | | 24c. REGISTRAR'S SIGNATURE | |
| NAME | | ADDRESS | | | |
| George R. Snowden | | 246 N. Washington St. Rockville, MD 20850 | | JAN 20 1986 | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial or final disposition. The funeral director should remove carbon paper and page 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

05-11-50



ONE 7 MATTING

REBIL NOTED 2:00

010129

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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1. FOR
STATE REGISTRAR
Edward Nelson Passapae

REG. NO.

| | | | | | |
|--|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) EDWARD rd PASSAPAE | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 7 1986 | | 2b. HOUR 5:30 PM | |
| 3 SEX M Male | 4 RACE W White | 5. DATE OF BIRTH MONTH DAY YEAR 10 21 19 | | 6 AGE (IN YEARS LAST BIRTHDAY) 66 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore md | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital ER | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Inspector | | 12b. KIND OF BUSINESS OR INDUSTRY Steel Mfg. |
| 13a. STATE md | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Dundalk | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Thomas M. Passapae | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nora Fowler | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 217/07/3571 | | 17. INFORMANT ADDRESS Vernon M. Passapae 7919 Wise Ave. 21222 | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|---|

| | | | |
|--|--|--|---|
| PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.] | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (this hospital) attended the deceased from <u>JANUARY 7 19 1986</u> to <u>JANUARY 7 19 86</u> , that (I) (we) last saw the deceased alive on <u>JANUARY 7 19 86</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | |
| 22b. SIGNATURE <u>L. B. Peredo</u> | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED <u>1/7/86</u> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) LUZVIMINDA K. PEREDO M.D. | | 22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MD. 21231 | |

| | | | |
|--|-----------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 1/9/1986 | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | 23d. LOCATION CITY OR TOWN COUNTY Baltimore, Maryland 21228 |
| 24. FUNERAL DIRECTOR NAME Walter Brooks Bradley Inc. Balto., Md. 21222 | | 25a. DATE REC'D. BY REGISTRAR JAN 8 1986 | 25b. REGISTRAR'S SIGNATURE <u>Edward Nelson Passapae</u> |

1910

7



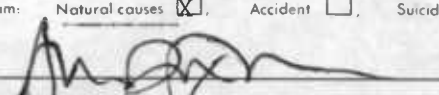
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | |
|---|--|------------------|----------------|--|--|---|--|---|----------------|---|--|---|--|---|----------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST ETHEL | | | MIDDLE DILLS | | | LAST PATTON | | | 2a. DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/> 1 5 19 86 | | | 2b. HOUR M | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR APRIL 16, 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7c. DATE PRONOUNCED DEAD 1 5 19 86 | | | 7d. HOUR A M 3:20 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 403 S. Collington Ave. | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER | | | | 12b. KIND OF BUSINESS OR INDUSTRY NONE | | | |
| 13a. STATE VIRGINIA | | | | 13b. COUNTY TAZEWELL | | 13c. CITY OR TOWN CEDAR BLUFF | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS P.O. BOX 463 /24609 99999 | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST MOSE THOMPSON DILLS | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST COLUMBIA BELLE ARMSTRONG | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) NONE | | 17. INFORMANT ADDRESS PAULINE E. GERMAN 471 BROADWATER RD. ARNOLD, MD. 21012 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | | | DATE SIGNED 1-5-86 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | | | | ADDRESS 111 Penn St., Balto., MD 21201 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL | | | | 23b. DATE JAN. 5, 1986 | | | | 23c. NAME OF CEMETERY OR CREMATORY GREENHILLS MEM. GARDENS | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE CLAYPOOL HILL TAZEWELL VA. | | | | | |
| 24. FUNERAL DIRECTOR NAME Robert E. Daxley & Son | | | | | | 615 EAST MAIN ST. THURMONT, MD. 21788 | | | | 25a. DATE RECEIVED BY REGISTRAR JAN 20 1986 | | | | 25b. REGISTRAR'S SIGNATURE | | | |

07/B4
25M

BP

DHMH - 17
(VR A15 ME (5))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXCUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS
AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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WATFORD
83014 NOTION NO. 2



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

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1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|---|--|--|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) RITA M. PAUL | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 1, 1986 | | 2b. HOUR 10:20 P ^M | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR January 16, 1924 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. | | 7. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 9b. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | 10. CITY OR TOWN OF DEATH BALTIMORE | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | 13b. COUNTY | | 13c. CITY OR TOWN Balto. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Weinhold | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Walsch | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | |
| 16b. SOCIAL SECURITY NO. 212-22-1121 | | 17. INFORMANT ADDRESS Sandra Tucker 1726 Drexel Ave. 21222 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30' | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>8/1/86</u> , 19 <u>86</u> , to <u>1/1</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>1/1</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE George Britten M.D. | | | | 22c. DATE SIGNED 1/1/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) George Britten | | | | 22e. ADDRESS Johns Hopkins Hospital. | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-5-86 | | 23c. NAME OF CEMETERY OR CREMATORY Garden of Faith | | |
| 23d. LOCATION CITY OR TOWN Baltimore | | 23e. COUNTY Md. | | 23f. STATE | | |
| 24. FUNERAL DIRECTOR NAME John M. Weber & Sons Inc. 401 S. Chester St. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 7 1986 | | |
| 25b. REGISTRAR'S SIGNATURE [Signature] | | | | 25c. [Signature] | | |

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1940 11 23



100% COTTON

100% COTTON

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER WITHIN 72 HOURS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MDHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01445

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | | | | | | | |
|--|--|---------|---|---|-------------------|--|---|---|---|-----------------------|--|-----------------------------------|--|-----------|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE KNOWN OF DEATH | | | MONTH DAY YEAR | | | 2b. HOUR | | | | | |
| JACK K. PAULSEN | | | | | | DATE ESTI- MATED | | | 1 7 19 86 | | | M | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | | | |
| Male | | White | | 4 2 71 | | 14 YRS. | | MONTHS DAYS | | HOURS MIN. | | 1 7 19 86 | | 7:49 P.M. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | |
| Maryland | | | USA | | | | | | Baltimore City | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Baltimore | | | University Hospital (STU) | | | | | | Student | | | | | | | | |
| 13a. STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | |
| Md. | | | Carroll | | Manchester | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 4900 Roller Road 21102 | | | | | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | |
| FIRST MIDDLE LAST | | | FIRST MIDDLE LAST | | | | | | | | | | | | | | |
| Edward M. Paulsen | | | Norma MacDonal | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | | | | | | | | | | |
| no | | | 213-04-2088 | | | Mr. Edward Paulsen, Manchester, Md. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Gunshot wound of neck (rifle) | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: | | | | | | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | 20. AUTOPSY? | |
| | | | | | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | |
| | | | | HOUR MIN. MONTH DAY YEAR | | | | | | | | | | | | | |
| | | | | 6:20 P.M. 1-7- 19 86 | | | | Subject was shot when gun discharged. | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | | | | | | |
| | | | | house | | | | 4904 Rollers Rd., Manchester, Carroll MD | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | | | | | | |
| Ann M. Dixon, M.D. | | | | M.D. Assistant | | | | MEDICAL EXAMINER | | | | 1-8-86 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | | | |
| Ann M. Dixon, M.D. | | | | 111 Penn St., Balto., MD 21201 | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | | | | | |
| Burial | | | | 1-10-86 | | Evergreen Mem. Gard. | | | | Finksburg Carroll Md. | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Elaine Funeral Home | | | | Hampstead, Md. | | | | JAN 9 1986 | | | | Julia Davidson-Rendall | | | | | |

MEDICAL CERTIFICATION

10000

10000

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10000

02300

11/17

11/17/80 DE MONTGOMERY

FEMALE

W. H. H.

On 11/17/80, a female white-headed woodpecker was banded at the same place as the male. It was 100% white-headed, with a white forehead, white crown, white nape, white back, white wings, white tail, white underparts, and white feet. It was 100% white-headed, with a white forehead, white crown, white nape, white back, white wings, white tail, white underparts, and white feet.

On 11/17/80, a female white-headed woodpecker was banded at the same place as the male. It was 100% white-headed, with a white forehead, white crown, white nape, white back, white wings, white tail, white underparts, and white feet. It was 100% white-headed, with a white forehead, white crown, white nape, white back, white wings, white tail, white underparts, and white feet.

On 11/17/80, a female white-headed woodpecker was banded at the same place as the male. It was 100% white-headed, with a white forehead, white crown, white nape, white back, white wings, white tail, white underparts, and white feet. It was 100% white-headed, with a white forehead, white crown, white nape, white back, white wings, white tail, white underparts, and white feet.

On 11/17/80, a female white-headed woodpecker was banded at the same place as the male. It was 100% white-headed, with a white forehead, white crown, white nape, white back, white wings, white tail, white underparts, and white feet. It was 100% white-headed, with a white forehead, white crown, white nape, white back, white wings, white tail, white underparts, and white feet.

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CHIEFLY

2011

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 1 4 4 7

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|--|--|---|--|---|---|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) ANNA PENNY | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 - 20 - 86 | | | 2b. HOUR 3:50 M | | | | |
| 3. SEX FEMALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 8 5 03 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LUTHERAN HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSE WIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE MD | | | 13b. COUNTY | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE 1506 N. APPLETON ST 21217 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST FOSTER SINGLETON | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VIOLA HARRISON | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 114-01-1026A | | 17. INFORMANT ADDRESS CHARLOTTE BRIGGS 1506 N. APPLETON ST | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) STATUS POST CPR DUE TO, OR AS A CONSEQUENCE OF (c) MULTIPLE OLD CEREBRAL INFARCTS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) RENAL FAILURE (b) HYPERTENSION (c) DIABETES (d) ATRIAL FIBRILLATION | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-3-1986 to 1-20-1986 , that (I) (we) last saw the deceased alive on 1-20-1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Anil N. Raiker | | | | | DEGREE MD | | | 22c. DATE SIGNED 1-20-86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANIL N. RAIKER | | | | | 22e. ADDRESS LUTHERAN HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 1/24/86 | | 23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEM. PARK | | 23d. LOCATION CITY OR TOWN COUNTY STATE ARBUTUS MD | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS WM C. BROWN COMM. F/H 1206-08 W. NORTH AVE. | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 23 1986 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

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(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Form 100-1 (Rev. 1-25-60)

NAME: [illegible]

ADDRESS: [illegible]

CITY: [illegible]

STATE: [illegible]

ZIP: [illegible]

DATE: [illegible]

SIGNATURE: [illegible]

PRINTED NAME: [illegible]

DATE: [illegible]

020256

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|---|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helen J. Petcholan | | | | 1 11 86 | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 9 15 20 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 65 YRS. | |
| 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 11. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Home Maker | |
| 13a. STATE Maryland | | | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN Baltimore | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Stanley Nowakowski | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Victoria Nurkowski | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 187 05 5702 | | 17. INFORMANT Joyce Petcholan Rush Pennsville N.J. | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Seizure disorder</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized tonic-clonic (alone at home)</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1970</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>no</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1 970</u> , 19____, to <u>1/11/86</u> , 19____, that (I) (we) lost saw the deceased alive on <u>6/20/85</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>S. Munese MD.</u> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. SILVINO MUNESSES | | | | 22e. ADDRESS 3721 POTEET ST. BALTIMORE, MD. 21225 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | 23b. DATE 1/15/86 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn A.A. Md. | |
| 24. FUNERAL DIRECTOR NAME George Gonce | | | | 4001 Ritchie Hwy. ADDRESS Baltimore Md. 21225 | | 25a. DATE REC'D. BY REGISTRAR JAN 16 1986 | |
| | | | | 25b. REGISTRAR'S SIGNATURE | | | |

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**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH**

REG. NO.

029016

**1. FOR
STATE
REGISTRAR**

| | | | | | | |
|---|---|---|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Roger D. Petersen | | | 2a. DATE OF DEATH MONTH DAY YEAR January 25, 1986 | | 2b. HOUR 8:25 AM | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR July 20, 1938 | 6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ. of Maryland Cancer Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY Education | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland | | 13c. COUNTY Baltimore | 13d. CITY OR TOWN Baltimore | 13e. STREET ADDRESS / ZIP CODE 1014 Argonne Drive 21218 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John D. Petersen | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary R. Gliavene | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 366-40-2531 | | 17. INFORMANT ADDRESS Courtney S. Petersen 1014 Argonne Dr. 21218 | | | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF (b) Superior Vena Caval Obstruction | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Right atrial mural thrombosis | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Relapsed Acute Undifferentiated Leukemia

| | | | |
|--|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/10/86 , 19____, to 1/25/86 , 19____, that (I) (we) lost saw the deceased alive on 1/24/86 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE Thomas J. Walsh M.D. | | 22c. DATE SIGNED 1/25/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas J. Walsh | | 22e. ADDRESS University of Maryland Cancer Center | |

| | | | |
|---|---------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE Jan 28 1986 | 23c. NAME OF CEMETERY OR CREMATORY South Victory Cem. | 23d. LOCATION CITY OR TOWN COUNTY STATE Victory Township Michigan |
|---|---------------------------------|---|--|

| | | | |
|--|---------------------------------------|---|--|
| 24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. | ADDRESS Baltimore, Maryland | 25a. DATE REC'D. BY REGISTRAR JAN 27 1986 | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> |
|--|---------------------------------------|---|--|

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, pages 1, 2, 3, and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified of one.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|--|--|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Kitty C PETZOLD | | | 2a. DATE OF DEATH MONTH DAY YEAR 11/3/86 | | 2b. HOUR 11:18 P.M. | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 3 31 47 | | 6. AGE (IN YEARS LAST BIRTHDAY) 38 YRS. | | IF UNDER YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) California | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALT CITY MD. | | |
| 10. CITY OR TOWN OF DEATH BALT CITY | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY MARYLAND | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY -- | |
| 13a. STATE MD | | | 13b. COUNTY HARFORD | 13c. CITY OR TOWN EDGEWOOD | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME (TYPE OR PRINT) JOSEPH S. XXXXXXXXXX Hall | | | 15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) LAVERNE XXXXXXXXXX Hoagland | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 549-74-8353 | | 17. INFORMANT ADDRESS Edgewood, Md. 21040 Robert W. Petzold, M.D., 2215 Perry Ave. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MELANOMA CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) BILATERAL PULMONARY INFILTRATES DUE TO, OR AS A CONSEQUENCE OF (c) MELANOMA | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22. I certify that (I) (the hospital) attended the deceased from 11/3/86 to 11/3/86, that (I) (last) saw the deceased alive on 11/3/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE R. J. Panos MD | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 11/4/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RJ PANOS | | | | 22e. ADDRESS UNIV of MD Hosp | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Jan. 8, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY Harford Memorial Gardens | | 23d. LOCATION CITY OR TOWN COUNTY STATE Aldino Harford Md. |
| 24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009 | | | | 25a. DATE REC'D. BY REGISTRAR JAN 7 1986 | | 25b. REGISTRAR'S SIGNATURE |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be retained by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner may need to be notified.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | |
|---|---|--|--|---|----------------------------------|
| 1 DECEASED NAME (TYPE OR PRINT) JOANA L. PEUGH aka JEAN L. PEUGH | | 2a DATE OF DEATH MONTH DAY YEAR 01 09 86 | | 2b HOUR 1 57 P.M. | |
| 3 SEX Female | 4 RACE WHITE | 5 DATE OF BIRTH MONTH DAY YEAR 12 29 31 | | 6 AGE (IN YEARS LAST BIRTHDAY) 54 YRS. | |
| 7a BIRTHPLACE (STATE OR FOREIGN) MD, USA | 7b CITIZEN OF WHAT COUNTRY? U.S.A | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD | |
| 10 CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore Gen Hosp | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b KIND OF BUSINESS OR INDUSTRY |
| 13a STATE MD | 13b COUNTY A.A. | 13c CITY OR TOWN Riviera Beach | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14 FATHER'S NAME JULIUS | | 15. MOTHER'S MAIDEN NAME THERESA | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | |
| 16b SOCIAL SECURITY NO. 219-28-3096 | | 17 INFORMANT Truman R. Peugh (same as 13c) | | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary Arrest DUE TO, OR AS CONSEQUENCE OF (b) Renal Insufficiency DUE TO, OR AS CONSEQUENCE OF (c) Cervical C.A. & Cirrhosis PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that this hospital attended the deceased from 1/9 1986 to 1/9 1986, that we last saw the deceased alive on 1/9 1986, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (do not) view the body after death. | | | | | |
| 22b SIGNATURE J. Griffin MD | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED 1/9/86 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) J. Griffin MD | | 22e ADDRESS 3001 S. Hanover St | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b DATE Jan. 13, 1986 | | 23c NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery | |
| 23d LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | 24 FUNERAL DIRECTOR NAME ADDRESS George J. Gonce, 4001 Ritchie Hg., Baltimore, MD | | | |
| 25a DATE REC'D. BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE JAN 13 1986 | | | |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the health department within 24 hours after death.

IMPORTANT: If item 21 is marked or item 18 is not injury, or other traumatic event, the medical examiner should be notified.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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017022

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|--|--|--|---|
| 1 DECEASED NAME (TYPE OR PRINT) ELIZABETH PEYTON | | | 2a DATE OF DEATH MONTH DAY YEAR JANUARY 11, 1986 | | 2b HOUR M |
| 3 SEX Female | 4 RACE Black | 5 DATE OF BIRTH MONTH DAY YEAR 10 23 15 | | 6 AGE (IN YEARS LAST BIRTHDAY) 70 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD. | | |
| 10 CITY OR TOWN OF DEATH Baltimore | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1217 W. Lafayette Avenue | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed | 12b KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a STATE Maryland | 13b COUNTY | 13c CITY OR TOWN Baltimore | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS / ZIP CODE 1217 W. Lafayette Avenue 21217 | |
| 14 FATHER'S NAME FIRST MIDDLE LAST | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Grayson | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-18-3508 | 17 INFORMANT ADDRESS Mary Hunter 1217 W. Lafayette Avenue | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Lung Cancer</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| MEDICAL CERTIFICATION | | | | | |
| 19a DATE OF OPERATION <u>9-17-85</u> | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>9-17-85</u> to <u>1-11-86</u> , that (I) (we) last saw the deceased alive on <u>11-19-85</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE <u>Alan Adelman, MD</u> | | DEGREE MD | | 22c DATE SIGNED 1-13-86 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Alan Adelman, MD | | 22e ADDRESS 600 Light St Balt 21230 | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b DATE 1/16/86 | 23c NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park | 23d LOCATION CITY OR TOWN COUNTY STATE Arbutus, Md. | 23e DATE REC'D. BY REGISTRAR JAN 15 1986 | |
| 24 FUNERAL DIRECTOR NAME March Funeral Homes 1101 East North Avenue | | | 25b REGISTRAR'S SIGNATURE | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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11-20-50

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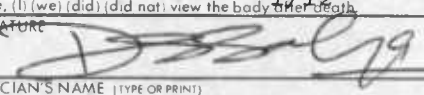



11-20-50

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FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|--|---|---|---|--|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) RALPH PHILLIPS | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 12, 1986 | | | 2b. HOUR 11:11P | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 11 26 22 | | 6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD. | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Police Officer | | 12b. KIND OF BUSINESS OR INDUSTRY Balto. City | | |
| 13a. STATE Md. | | | 13b. COUNTY | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles Phillips | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sara Sweeney | | | 13e. STREET ADDRESS / ZIP CODE 140 W. Lafayette Ave. 21217 | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1943-46 | | 17. INFORMANT ADDRESS | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Cerebrovascular accident | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/12/ 19 86 to 1/12 19 86 , that (I) (we) lost saw the deceased alive on 1/12 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE  | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. Saluji M.D. | | | 22e. ADDRESS 1600 M T Royal Ave, Balto 21217 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | | 23b. DATE 1/14/86 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR NAME Anatomy Board | | | | | ADDRESS Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR JAN 24 1986 | | 25b. REGISTRAR'S SIGNATURE  | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, the certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | REG. NO. | |
|--|--|--|-----------------------------------|--|----------------------------------|---|
| 1. FOR STATE REGISTRAR | | | 2a. DECEASED NAME (TYPE OR PRINT) | | 2b. DATE OF DEATH MONTH DAY YEAR | |
| FIRST MARY MIDDLE - LAST PICCOLO | | | | | JAN 30 1986 8 35 AM | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SEAMSTRESS | | 12b. KIND OF BUSINESS OR CLOTHING AMALGAMATED CLOTHING |
| 13a. STATE MD. | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST CARMELO MANCUSO | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CARMELA LAPORTA | | 13e. STREET ADDRESS / ZIP CODE 2823 BRENDAN AVE. 21213 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 216-03-0729 | | 17. INFORMANT ADDRESS 3105 HILLCREST AVE. 21234 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | |
| IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) SEPSIS | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: PNEUMONIA, INTRAVENTRICULAR HEMORRHAGE | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (1) the hospital attended the deceased from 1/29 1986 to 1/30 1986, that (2) we last saw the deceased alive on 1/29 1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (3) we did not view the body after death. | | | | | | |
| 22b. SIGNATURE John Budin MD | | | | 22c. DATE SIGNED 1/30/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN BUDIN | | | | 22e. ADDRESS UNION MEM HOSP 201 E UNIV PKWY | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 2/3/86 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. |
| 24. FUNERAL HOME NAME SCHIMUNEK FUNERAL HOME, INC. 3331 Brehms Lane, Balto. Md. 21213 | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | |
| | | | | JAN 31 1986 John Budin | | |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director. Page 3 should be detached for use as the burial/transit permit. Then place remains in casket. Pages 1 and 2 should be filled in with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or this is a violent event, it must be noted on page 4.

| STATE OF MARYLAND 8 6 0 1 4 5 5 | | | | | | | | | |
|---|--|--|---|---|--|--|---|--|--|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. | | | | | | | | | |
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LOVATA SUSANNA PINKETT | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 3, 1986 | | 2b. HOUR P 11:22 AM | |
| 3. SEX FEMALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YRS. 01 13 86 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cook | | 12b. KIND OF BUSINESS OR INDUSTRY Food | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD | | | | | | 13c. CITY OR TOWN FREDERICK MT. AIRY | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WADE FRIDY | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AMIE GIBSON | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A | | 17. INFORMANT AMIE HACKETT | | ADDRESS Mt. Airy, MD 21771 13936 Prospect Rd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Vascular disease Approximate interval between onset and death: approx 3 to 5 min | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> POST WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov 9 19 85 to Jan 3 19 86 that (I) (we) last saw the deceased alive on Jan 3 19 86, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (Do not check) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Jeffrey Kane | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED JAN/3/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jeffrey Kane | | | 22e. ADDRESS Johns Hopkins Hosp 600 N. WOLFE STREET - BALTO, MD 21205 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 1/8/86 | | 23c. NAME OF CEMETERY OR CREMATORY Dorsey U.M. Church Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE New London Frederik MD | | |
| 24. FUNERAL DIRECTOR NAME G. Douglas Stauffer | | | | | | 25a. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE JAN 7 1986 | | | |
| 1621 Opossumtown Pike, Frederick, MD | | | | | | | | | |

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| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|---|---|--|--|--|
| REG. NO. | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) <i>Bertha Plummer</i> | | | | | 2a. DATE OF DEATH MONTH <i>Jan</i> DAY <i>15</i> YEAR <i>1986</i> | | | | | 2b. HOUR <i>3:20 PM</i> | | | |
| 3. SEX <i>Female</i> | | 4. RACE <i>Black</i> | | 5. DATE OF BIRTH MONTH <i>6</i> DAY <i>25</i> YEAR <i>95</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>90</i> YRS. | | IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i> | | IF UNDER 24 HRS HOURS <i></i> MIN. <i></i> | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Brentwood Md</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Baltimore City</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Kensco Ngt Home - 2922 Arundel Ave</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>House wife</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE <i>MD</i> | | | | | 13b. COUNTY <i>Baltimore</i> | | 13c. CITY OR TOWN <i>Baltimore</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS <i>2922 Arundel AVE 21216</i> | |
| 14. FATHER'S NAME FIRST <i>Peter</i> MIDDLE <i></i> LAST <i>Randall</i> | | | | | 15. MOTHER'S MAIDEN NAME FIRST <i>Barbara</i> MIDDLE <i></i> LAST <i>Johnson</i> | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Thelma Hodge</i> | | | | | ADDRESS <i>1101 Nalley Rd #1033 Landover Md</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest.</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Congestive Heart failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Diffuse Generalized Arteriosclerosis</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Senile Dementia</i> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <i>March 15, 1984</i> to <i>January 7, 1986</i> , that (I) (we) last saw the deceased alive on <i>January 7, 1986</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we, they) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>Schue-Yuan Liao, M.D.</i> | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED <i>1/16/86</i> | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Schue-Yuan Li'ao, M.D.</i> | | | | | 22e. ADDRESS <i>Rm 215 Osler Medical Center 7600 Osler Dr, Towson, Md. 21204</i> | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | | 23b. DATE <i>1/20/86</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Harmony Memorial Park</i> | | | 23d. LOCATION CITY OR TOWN <i>Landover, PG, Maryland</i> COUNTY STATE | | | | | |
| 24. FUNERAL DIRECTOR <i>ALEXANDER S. POPE</i> | | | | | ADDRESS <i>2617 Pa Ave S.E. Wash., D.C.</i> | | 25a. DATE REC'D. BY REGISTRAR <i>JAN 29 1986</i> | | 25b. REGISTRAR'S SIGNATURE <i>James R. Anderson</i> | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Burial may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 30 DAYS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
 EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER CERTIFICATE. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
 BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

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STATE
REGISTRAR
 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|---------|--|------------------------------------|--|---|--|----------------------------------|---|----------------------------------|--|--|--|--|--------------------------------------|--|--|---|--|--|---------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST CAREY | | | MIDDLE S. | | | LAST POETZMAN | | | 2a. DATE KNOWN OF DEATH ESTI- MATED | | | XX MONTH DAY YEAR | | | 1-19 19 86 | | | 7b. HOUR M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YR. MONTHS DAYS | | 8. IF UNDER 24 HRS. HOURS MIN | | 2c. DATE PRONOUNCED DEAD | | | MONTH DAY YEAR | | | 1-19 19 86 | | | 2d. HOUR M | | |
| Female | | White | | 10 2 1957 | | 28 YRS. | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | | |
| Maryland | | | USA | | | | | | Baltimore City, MD. | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| Baltimore | | | Leakin Pk.-west of 1100 blk. Hil- ton Parkway | | | | | | | | | Medical Tech | | | Helicopter | | | | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS | | | | | | | | | | | |
| Maryland | | | Carroll | | | Manchester | | | | | | 2563 Fbbvale Road 21102 | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | | | | | | | | | | | | | |
| Robert L. Poetzman | | | Margery Lou Jennette Ford | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | | | | | | | | | | | | | | | | |
| no | | | 21 6-70-0560 | | | Mr. Robert J. Simpson, Manchester, Md. | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Injuries</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 1a. | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | | | |
| 4:05 PM 1-19 19 86 | | | co-pilot in helicopter crash | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | |
| Park | | | west of 1100 blk. Hilton Pkwy., Balto., Md. | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | TITLE (SPECIFY) M.D. Assistant | | | MEDICAL EXAMINER | | | DATE SIGNED 1-20-86 | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | ADDRESS | | | | | | | | | | | | | | | | | | | | |
| Dennis F. Smyth, M.D. | | | 111 Penn St., Balto., Md. 21201 | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | |
| Burial | | | 1-23-86 | | | Immanuel Cemetery | | | Manchester Carroll Md. | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR | | | | | | | | | | | | | | | | | |
| Eline Funeral Home, Hampstead, Md. | | | | | | JAN 27 1986 | | | | | | | | | | | | | | | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|---|--|---|--|---|-------------------------|---|--|---|--|-------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) LEONARD C. POORE | | | 2a. DATE OF DEATH MONTH DAY YEAR JAN. 18, 1986 | | 2b. HOUR 2:40 A M | | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 24 1932 | | 6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | IF UNDER 72 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Millwright | | 12b. KIND OF BUSINESS OR INDUSTRY Ind. | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY Cecil | | 13c. CITY OR TOWN Elkton | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE Poore La. 21921 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Harry Poore | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Holmes | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korea 217-28-2635 | | 17. INFORMANT ADDRESS Lillian Poore P.O. Box 782 Elkton, Md. 21921 | | | | | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Aplastic Anemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1hr 24hrs. 3 months |
|--|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION 12/17/85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Bone marrow transplant on 12/17/85 | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>November 11, 1985</u> to <u>January 18, 1986</u> , that (I) (we) last saw the deceased alive on <u>January 18, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Roger Blumenthal | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/18/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Roger Blumenthal, M.D. | | | | 22e. ADDRESS Johns Hopkins Hospital - Dept. of Medicine, Balto. MD 21205-600 N. WOLFE ST. | | | |

| | | | | | | | |
|--|--|----------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-21-86 | | 23c. NAME OF CEMETERY OR CREMATORY Charlestown Cem. | | 23d. LOCATION Charlestown Cecil Md. | |
|--|--|----------------------|--|--|--|--|--|

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|---|--|---|--|---|--|
| 24. FUNERAL DIRECTOR NAME Such Funeral Home North East, Md. | | 25a. DATE REC'D BY REGISTRAR JAN 28 1986 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |
|---|--|---|--|---|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DEFINITION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

FOR
1. STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---------------------|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) Lillie E. POPE | | | 2a. DATE OF DEATH MONTH DAY YEAR January 29, 1986 | | 2b. HOUR 6:18PM |
| 3. SEX F | 4. RACE B | 5. DATE OF BIRTH MONTH DAY YEAR 8 29 31 | | 6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Maryland | | | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Eddie Scott | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie M. Stringfield | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Elouise Scott 1604 East 29th Street | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Pancreatic carcinomatosis DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Hepatic failure | | | | | |
| 19a. DATE OF OPERATION 1/13/86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of the pancreas | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 27 , 19 86 , to January 29 , 19 86 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on January 29 , 19 86 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (do not) view the body after death. | | | | | |
| 22b. SIGNATURE J.S. Rosen. MD | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1-30-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J.S. Rosen. MD | | 22e. ADDRESS c/o Maryland General Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 2/3/86 | | 23c. NAME OF CEMETERY OR CREMATORY Mount Auburn Cemetery | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md. | | 24. FUNERAL DIRECTOR NAME ADDRESS March Funeral Homes 1101 East North Avenue | | | |
| 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

FEB 03 1986

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NOTION 202



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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Page 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|---|---|--|---|--|
| FOR 1. STATE REGISTRAR | | | | | REG. NO. | | | | |
| 2a. DECEASED NAME (TYPE OR PRINT) Lillian Louise Popp | | | | | 2b. DATE OF DEATH MONTH DAY YEAR 1 24 86 2b. HOUR 9:20AM | | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 8 12 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto. County MD. | | | |
| 10. CITY OR TOWN OF DEATH Catonsville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Domestic | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | 13b. COUNTY Balto | | 13c. CITY OR TOWN Catonsville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 500 Dorchester St. 21228 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Henry Lawrence Reifner | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Eliza Kolb | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 216-01-7213 | | 17. INFORMANT ADDRESS Raymond Popp. 3247 Magnolia Ave. Balto, Md. 21227 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Atherosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Chronic Obstructive Pulmonary Disease (c) Retinitis Pigmentosa PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes years years |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE James J. Nathan | | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 1/24/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) NOLAN | | | | | 22e. ADDRESS 1 Malvern Hill Rd Baltimore Md 21229 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 27 Jan 86 | | 23c. NAME OF CEMETERY OR CREMATORY Louden Park Cem | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto City MD | | | |
| 24. FUNERAL DIRECTOR NAME Slack Funeral Home | | | | | ADDRESS Bx 268 Ellicott City, Md. 21043 | | 25a. DATE REC'D. BY REGISTRAR JAN 29 1986 | | |
| | | | | | 25b. REGISTRAR'S SIGNATURE | | | | |

016101

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | | | |
|---|--|---|---|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Isabella R Potteiger</u> | | | 2a. DATE OF DEATH MONTH DAY YEAR <u>1 11 86</u> | | | 2b. HOUR <u>3:20 am</u> | |
| 3. SEX <u>Female</u> | | 4. RACE <u>White</u> | | 5. DATE OF BIRTH MONTH DAY YEAR <u>09 07 1910</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>75</u> YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Penna.</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD. | |
| 10. CITY OR TOWN OF DEATH <u>Baltimore</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Mercy Hospital Balto. Md.</u> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE <u>MD</u> | | | | 13b. COUNTY <u>Baltimore</u> | | 13c. CITY OR TOWN <u>Baltimore</u> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <u>Ruffus unknown -- Barnett</u> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Salley unknown Unknown</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>unknown -- No</u> | | 16b. SOCIAL SECURITY NO. <u>212343439</u> | | 17. INFORMANT <u>113 Willow Brook Dr. Pasa, 21122</u> <u>medical chart William Potteiger</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Heart block</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>emphysema</u> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u> |
| | | | | | | | <u>years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0 <u>none</u> | | | | | | | |
| 19a. DATE OF OPERATION <u>N/A</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>N/A</u> | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>N/A</u> <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <u>N/A</u> | | | |
| 21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>N/A</u> | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>N/A</u> | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/29</u> , 19 <u>85</u> , to <u>1/11</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>3:20 am 1/11</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Matthew G. Wagner</u> MD | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>1/11/86</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Matthew G. Wagner</u> | | | | 22e. ADDRESS <u>301 St. Paul Pl Mercy Hospital Baltimore MD</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>1/14/86</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Balto. A.A.Co. Maryland</u> | |
| 24. FUNERAL DIRECTOR NAME <u>McElroy F.H. Hest</u> | | | | 25a. DATE REC'D. BY REGISTRAR <u>JAN 13 1986</u> | | 25b. REGISTRAR'S SIGNATURE <u>John Swider</u> | |

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DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. HAVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
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STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | |
|---|--|--------------|---|---|--|---|--|---|---------------|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST CHRISTINE DELORIS POWELL | | | 2a. DATE KNOWN OF DEATH X MONTH DAY YEAR 1-7-86 19 | | | 7b. HOUR M | | | | | | |
| 3. SEX F | | 4. RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR 4 12 32 | | 6. AGE (IN YEARS) LAST BIRTHDAY YRS. 53 | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1-7-86 19 | | 7d. HOUR 9:56A | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Bon Secour Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | 21223 | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2225 W. BALTIMORE ST. | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOHN P. EDWARDS | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DAISY WILLIAMS | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 243-52-9487 | | 17. INFORMANT ADDRESS ERNESTINE WILLIAMS 2225 W. BALTIMORE | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Margarita A. Korell</u> | | | | TITLE (SPECIFY) M.D. Assistant | | | | DATE SIGNED 1-7-86 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL BURIAL | | | | 23b. DATE 1-15-86 | | 23c. NAME OF CEMETERY OR CREMATORY RICHARDSON | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE ALSTON NASHVILLE N.C. | | | | | |
| 24. FUNERAL DIRECTOR NAME WM.C.MARCH F/H INC. | | | | | | ADDRESS 1101 E. NORTH AVE. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 10 1986 | | 25b. REGISTRAR'S SIGNATURE <u>Richardson</u> | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Winfel Powell | | | 2a. DATE OF DEATH MONTH DAY YEAR January 3, 1986 | | 2b. HOUR M | | | | | | |
| 3 SEX Male | | 4 RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 10 20 14 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2645 Aisquith Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel | | | |
| 13a. STATE Maryland | | | | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Jonas Powell | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie McGriff | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 423-10-1371 | | 17. INFORMANT ADDRESS Christine Powell 2645 Aisquith Street | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Small Cell Lung Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 mos</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/85</u> 19 <u>85</u> , to <u>Jan</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>12</u> 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Paul Celardo, MD</u> | | | | | | DEGREE <u>MD</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>1/6/86</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>PAUL CELARDO, MD</u> | | | | | | 22e. ADDRESS <u>Johns Hopkins Oncology CR Baltimore</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL BURIAL | | | 23b. DATE 1/7/85 | | 23c. NAME OF CEMETERY OR CREMATORY Md. National Mem Pk. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Laurel, Md. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Marshall Funeral Homes 1101 East North Avenue | | | | | | 25a. DATE REC'D. BY REGISTRAR <u>JAN 7 1986</u> | | 25b. REGISTRAR'S SIGNATURE <u>Johnston</u> | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial permit. Then please remove the pages. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified of same.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 014641

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) JOHN Lee POWERS | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 24, 1986 | | 2b. HOUR 3:00 ^A |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 11 12 44 | | 6. AGE (IN YEARS LAST BIRTHDAY) 41 | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Marketing Dept. | | 12b. KIND OF BUSINESS OR INDUSTRY A.H. Robins |
| 13a. STATE Virginia | 13b. COUNTY Henrico | 13c. CITY OR TOWN Richmond | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 3002 Rudolph Road 23229 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Daniel C. Powers, Sr. | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anne Collier | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 227-58-7211 | | 17. INFORMANT ADDRESS 3002 Rudolph Road Janice Kay Powers Richmond, VA. 23229 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARDS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Probable Sepsis</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u> <u>50 days</u> <u>3 days</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Acute Myelocytic Leukemia; S/P Bone Marrow Transplant</u> | | | | | |
| 19a. DATE OF OPERATION <u>12/30/85</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Acute Myelocytic Leukemia</u> | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Dec. 17</u> 19 <u>85</u> to <u>Jan. 24</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>Jan. 24</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Roger Blumenthal</u> | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <u>1/24/86</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Roger Blumenthal</u> | | 22e. ADDRESS <u>Johns Hopkins Hospital, Tower 110 Baltimore, MD 21205</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | 23b. DATE <u>1-27-86</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Mem. Gardens</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Richmond Goochland VA</u> | |
| 24. FUNERAL DIRECTOR NAME <u>Loring Byers Funeral Directors, Inc.</u> | | 25. DATE RECEIVED BY FUNERAL DIRECTOR <u>JAN 28 1986</u> | | 26. REGISTERED SIGNATURE <u>Registrar</u> | |
| 8728 Liberty Rd. Randallstown, MD 21133 | | | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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3000-10100-0000

WILKINSON



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|---|--|---|------------------------------------|--|-------------------|--|------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR | |
| Cecelia | | | | Pratt | 1 25 86 | | | | | 1:45 M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Female | | White | | 7 MONTH DAY YEAR 7 02 01 | | 84 YRS | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | | U.S.A. | | | | Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | Francis Scott Key Hospital | | | | Housewife | | Home Maker | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | |
| Maryland | | A.A. | | Glen Burnie | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 284 Marley Avenue | | 21061 | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST Frank Simmons | | | | FIRST MIDDLE LAST Mary ===== | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | |
| No | | | | 212-20-9852 | | Albert S. Grzech | | Same as 13e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>cardiovascular arrest</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| (b) <u>severe diabetes</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) <u>stroke</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION | | | | | |
| WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (this hospital) attended the deceased from <u>1/4</u> , 19 <u>86</u> , to <u>1/25</u> , 19 <u>86</u> , that (we) last saw the deceased alive on <u>1/27</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | 22c. DATE SIGNED | | | |
| <u>Brenda W. Cogswell MD</u> | | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 1/27/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | | | |
| Brenda W. Cogswell MD | | | | | | Francis Scott Key Medical Center | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | |
| Burial | | | 1/29/86 | | Cedar Hill Cemetery | | Baltimore A.A. Md | | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| George J. Gonce 4001 Ritchie Hwy Balto Md | | | | | | JAN 28 1986 | | <u>John Davidson-Randall</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be kept with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.

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JAN 28 1986

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

014661

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Philipppo PHILLIP | | MIDDLE PRESTIFILLIPPO | | 2a. DATE OF DEATH MONTH DAY YEAR January 24, 1986 | | 2b. HOUR 2:55 P.M. | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 25 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER BALTIMORE MD | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired-Mechanic | | 12b. KIND OF BUSINESS OR INDUSTRY Jack's Tire | |
| 13a. STATE Md. | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Middle River | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Angelo PRESTIFILLIPPO | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosa Perna | | 16. SOCIAL SECURITY NO. 236 07 2999 | | | |
| 17. INFORMANT ADDRESS Kyle Lindsay 58 S. Hawthorne Road 21221 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (a) _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from January 24, 19 86 to January 24, 19 86 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on January 24, 19 86 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Salvatore | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/24/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SALVATERRA | | 22e. ADDRESS 3900 Loch Raven Blvd. Baltimore MD 21218 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/27/86 | | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Balto. Maryland | |
| 24. FUNERAL DIRECTOR NAME Connelly Funeral Home | | | | 25a. DATE REC'D BY REGISTRAR JAN 28 1986 | | 25b. REGISTRAR'S SIGNATURE Davidson-Rodell | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and deliver them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

BP

SECTION 100-1000

NOT RECORDED



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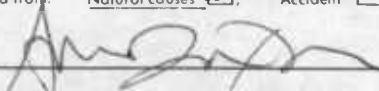
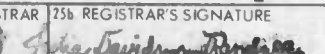
DHMH - 17
(VR A15 ME (5))

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER OF THE COUNTY OF BALTIMORE. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR DISPOSAL

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | REG. NO. | |
|--|-----------------------------|---|--|---|---|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) HERMAN PRZYBYLA | | | | | | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH DAY YEAR <input checked="" type="checkbox"/> 1 16 19 86 | |
| 3 SEX Male | 4 RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 7 9 10 | 6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 17 19 86 2d. HOUR 9:45 A.M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1417 Woodall St. | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Merchant Seaman | | 12b. KIND OF BUSINESS OR INDUSTRY Seaman |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 1474 Woodall St. 21230 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Przybyla | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Unkn. | | 16b. SOCIAL SECURITY NO. 086-12-3556 | | 17. INFORMANT ADDRESS Jerome Klemkowski 1473 Woodall St. 21230 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE  | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 1-17-86 | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | ADDRESS 111 Penn St., Balto., MD 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 2/13/86 | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arudel Co., Maryland | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS McCully Fun. Home 130 E. Fort Ave. 21230 | | | | 25a. DATE REC'D BY REGISTRAR FEB 05 1986 25b. REGISTRAR'S SIGNATURE  | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH | | | |
| I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY ANN Pullen | | | | MONTH DAY YEAR 1/30/1986 | | 2b. HOUR 9:50 a.m. | |
| 3. SEX F | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR 12 15 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Edgewood Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY --- | |
| 13a. STATE MD | | 13b. COUNTY Balto | | 13c. CITY OR TOWN Whitemarsh | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Alec Fluharty | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Henning | | 13e. STREET ADDRESS / ZIP CODE 6023 Loreley Beach Rd. 21162 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 212-30-3317 | | 17. INFORMANT ADDRESS Effie A. Pullen 6023 Loreley Beach Rd. 21162 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Aspiration pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>Severe senile dementia on tube feeding.</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 21. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>6/30/85</i> to <i>1/30/86</i> , that (I) (we) lost saw the deceased alive on <i>1/30/86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>[Signature]</i> | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/30/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) KHIN M. TUN | | 22e. ADDRESS 1006 Taylor Avenue Md 21204 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 1/31/86 | | 23c. NAME OF CEMETERY OR CREMATORY Security Process Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto. Md. | |
| 24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. | | ADDRESS 4107 Wilkens Ave. | | 25a. DATE REC'D. BY REGISTRAR FEB 03 1986 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

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Application for

State of New York

Chapter 22

AND

Section 10

FEB 03 1965

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|---------|--|---|--|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR | | |
| FRANCIS CHARLES QUIRK | | | 1-21-86 | | | M | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR. | 7c. DATE PRONOUNCED DEAD | 2d. HOUR | | |
| MALE | WHITE | JAN. 19, 1920 | 66 YRS. | | 1-21-86 | 2:25 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| MARYLAND | | USA | | | | Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | Johns Hopkins Hospital | | | (RET) CLERK | | FED. GOVT. | |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | |
| MD | | | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 13e. STREET ADDRESS | | | | |
| MICHAEL | | ELLEN | | 1029 EAST BALTIMORE ST. 21201 | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | |
| NO | | 219 01 6448 | | MISS ELIZABETH QUIRK, 100 REVOLUTION ST. HdG, MD. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY: | | | | | | | | |
| IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| (c) | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | |
| | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | | |
| WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/> | | | | | CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE | | | TITLE (SPECIFY) | | | DATE SIGNED | | |
| Margarita A. Korell, M.D. | | | Assistant | | | 1-21-86 | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | ADDRESS | | | | | |
| | | | 111 Penn Street | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| BURIAL | | | 25 JANUARY 86 | | MT. ERIN CEMETERY | | HAVRE de GRACE, HARFORD CO., MD. | |
| 24. FUNERAL DIRECTOR | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078 | | | JAN 24 1986 | | | John Davidson-Rendell | | |

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25M

BP
DHMH - 17
(VR A15 ME (5))

058017



035084

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | |
|--|---|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) ELIZABETH H. RAFFERTY | | | 2a. DATE OF DEATH MONTH DAY YEAR January 29, 1986 | | 2b. HOUR 2:00 P _M |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 20, 1915 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9 Midvale Road | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 13a. STATE MD | | | 13b. COUNTY | 13c. CITY OR TOWN Balto. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Carroll Henkel | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Hess | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 216 46 3536 | | 17. INFORMANT ADDRESS William B. Rafferty, Same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Nodular lymphoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 19 81</u> to <u>Jan 29 19 86</u> , that (I) (we) lost saw the deceased alive on <u>Jan 29 19 86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Davis M. Hahn</u> MD | | DEGREE MD | | 22c. DATE SIGNED 1/30/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Davis M. Hahn, MD | | 22e. ADDRESS Good Samaritan Hospital, Balto., MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | 23b. DATE 1/30/86 | 23c. NAME OF CEMETERY OR CREMATORY Green Mount | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto., MD | |
| 24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212 | | | 25a. DATE RECEIVED BY REGISTRAR JAN 31 1986 | | |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. Name: [illegible]
2. Address: [illegible]
3. City: [illegible]
4. State: [illegible]
5. Zip: [illegible]
6. Phone: [illegible]
7. Email: [illegible]
8. Date: [illegible]

9. Signature: [illegible]
10. Date: [illegible]
11. Address: [illegible]
12. City: [illegible]
13. State: [illegible]
14. Zip: [illegible]
15. Phone: [illegible]

017131

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|---|----------------------------|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Edith Rainey | | | 2a. DATE OF DEATH MONTH DAY YEAR January 13, 1986 | | 2b. HOUR M AM | | | | | | |
| 3 SEX Female | | 4 RACE Black | | 5 DATE OF BIRTH MONTH DAY YEAR Sept. 9, 1917 | | 6 AGE (IN YEARS LAST BIRTHDAY) 68 | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS. | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2444 Druid Hill Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 2444 Druid Hill Ave. 21217 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Landon Bayne | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Mitchell | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF NEW OR IN WAR OR DATES) N/A | | 17. INFORMANT ADDRESS Howard Walker 2504 Guildord Ave. 21218 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLISM DUE TO, OR AS A CONSEQUENCE OF, (b) ADENOCARCINOMA COLON Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) 5 yrs | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hours | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I DIABETES MELLITUS | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 11/13/86 | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-1-85 to 1/13/86 that (I) lost saw the deceased alive on 11-1-85 and that in (my) opinion death occurred on the date and hour and from the causes stated above, (that I) (we) did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Richard F. Tyson, M.D. | | | | DEGREE M.D. | | | | 22c. DATE SIGNED 01/14/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard F. Tyson M.D. | | | | 22e. ADDRESS 936 West North Ave Balt. Md. 21217 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/18/86 | | 23c. NAME OF CEMETERY OR CREMATORY Eastview Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Ieroy O. Dyett 4600 Liberty Hghts. Ave. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 14 1986 | | 25b. REGISTRAR'S SIGNATURE Richard F. Tyson | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or examined by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10131



10131

10131

10131

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHFOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|--|---|--|---|---|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) LUCY Green RANDALL | | | 2a DATE OF DEATH MONTH DAY YEAR 01 28 86 | | | 2b HOUR 9⁰⁰ A.M. | | | |
| 3 SEX Female | | 4 RACE Black | | 5 DATE OF BIRTH MONTH DAY YEAR 11 30 31 | | 6 AGE (IN YEARS LAST BIRTHDAY) 54 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Balto City MD. | | | |
| 10 CITY OR TOWN OF DEATH Balto | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Custodian | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland | | | 13b COUNTY Baltimore | | 13c CITY OR TOWN Baltimore | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST C Charles Green, Sr. | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy | | | 17 INFORMANT ADDRESS Vanessa Randall 4914 REisterstown Road | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b SOCIAL SECURITY NO. 215-28-3442 | | | 17 INFORMANT ADDRESS Vanessa Randall 4914 REisterstown Road | | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Breast carcinoma DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from April 19 88 , to Jan 28 19 86 , that (I) (we) lost saw the deceased alive on Jan 28 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE Marvin J. Friedman | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/28/86 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) MARVIN J. FRIEDMAN | | | | | | 22e ADDRESS 302 Greenspring Station, Lutherville, MD 21083 | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 2-1-86 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill | | 23d LOCATION CITY OR TOWN COUNTY STATE Annapolis Maryland | | |
| 24 FUNERAL DIRECTOR NAME WM. C. March F/H INC. | | | | | | ADDRESS 1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR JAN 31 1986 | |
| 25b. REGISTRAR'S SIGNATURE John Davidson-Randall | | | | | | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, portions should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

032111



WATER

WATER



JAN 21 1982

017105

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|---|--|---|---|--|---|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) ESTELLE F. RAPP | | | 2a. DATE OF DEATH MONTH DAY YEAR January 13, 1986 | | 2b. HOUR 1:30 P M | | | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 23, 1877 | | 6. AGE (IN YEARS LAST BIRTHDAY) 108 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 7b. IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3702 Falt Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper | | 12b. KIND OF BUSINESS OR INDUSTRY Photo | | | |
| 13a. STATE MD | | | 13b. COUNTY | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 3702 Falt Ave., 21224 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Henry Rapp | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Bell | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216 09 1747 | | | 17. INFORMANT Anne Blaney, | | | ADDRESS Same | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sensent lung disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Probable pneumonia</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (d), STATING THE UNDERLYING CAUSE LAST. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min 20 Yrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>August 15</u> , 19 <u>83</u> , to <u>Jan 13</u> , 19 <u>86</u> , that (I) (last saw the deceased alive on <u>1/3</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Chas. O'Donovan</u> | | | DEGREE (MD) | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 1/14/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Charles O'Donovan, MD | | | 22e. ADDRESS 9 E. Chase St., Balto., MD | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | 23b. DATE 1/14/86 | | 23c. NAME OF CEMETERY OR CREMATORY Green Mount | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto., MD | | | | |
| 24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212 | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 14 1986 | | 25b. REGISTRAR'S SIGNATURE <u>Gabe Landon-Randall</u> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

011110

January 12, 1963

FBI

RE

Baltimore City

X

USA

Bookkeeper
6702 Fair Ave.,
Baltimore, Md.

X

Baltimore

Cell

Room

Room

Room

Room

Room 1267 and 1268

Room

Baltimore, Md.

Baltimore, Md.

MD

Baltimore

Green Mount

11445

Green Mount

11445 Green Mount

MD


11445 Green Mount

014056

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | |
|--|--|----------------------|--|--|--|--|--|--|--|----------------------------|--|--|--|-------------------------|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) RUBEN (REUBEN) | | FIRST C. | | MIDDLE | | LAST RASCOE (ROSCOE) | | 2b. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH 1 DAY 8 YEAR 1986 | | | | 2d. HOUR 6:08 AM | | | | | | | |
| 3. SEX male | | 4. RACE black | | 5. DATE OF BIRTH MONTH 9/24/1905 DAY YEAR | | 6. AGE (IN YEARS) (LAST BIRTHDAY) 80 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | | 2c. DATE PRONOUNCED DEAD MONTH 1 DAY 8 YEAR 1986 | | 2d. HOUR 6:08 AM | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. C. | | | | 7b. CITIZEN OF WHAT COUNTRY? U S A | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1115 N. Calhoun St. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Presser | | | | 12b. KIND OF BUSINESS OR INDUSTRY Cleaners | | | | | | | |
| 13a. STATE Md | | | | 13b. COUNTY Baltimore | | | | 13c. CITY OR TOWN Baltimore | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS 1114 Calhoun Street 21217 | | | |
| 14. FATHER'S NAME FIRST Roderick MIDDLE D. LAST Rascoe | | | | 15. MOTHER'S MAIDEN NAME FIRST Aurora MIDDLE Bond LAST Bond | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS Washington D.C. Joshua T. Rascoe 2004 E. Street N. E. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 1-8-86 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | | ADDRESS 111 Penn St., Balto., MD 21201 | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 1/11/86 | | | | 23c. NAME OF CEMETERY OR CREMATORY Indianwood Baptist Church | | | | 23d. LOCATION CITY OR TOWN Windsor COUNTY N.C. STATE N.C. | | | | | | | |
| 24. FUNERAL DIRECTOR NAME William C. March West ADDRESS 4300 Wabash Avenue | | | | | | | | 25a. DATE REC'D BY REGISTRAR JAN 10 1986 | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17
(VR A15 ME (5))



Handwritten signature or initials.

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | |
|---|--|--|---|---|---|---|---|---|---|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) ELLIOTT RAY JR | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 9, 1986 | | 2b. HOUR 9:20PM | | | | | | | | | | |
| 3. SEX M | | 4. RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR 9 15 18 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 67 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ARKANSAS | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECURITY | | 12b. KIND OF BUSINESS OR INDUSTRY GUARD | | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 1313 E. NORTH AVE. 21213 | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ELLIOTT RAY SR. | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JULIA MCBRIDE | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN) YES | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 432-07-8498 | | 17. INFORMANT ADDRESS PHILISTEAN RAY 1313 E. NORTH AVE. | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>probable myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>calamitous disease</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>none</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> | | | | | | | |
| | | | | | | | | <u>1 hour</u> | | | | | | | |
| | | | | | | | | <u>3 years</u> | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/6</u> , 19 <u>86</u> , to <u>1/9</u> , 19 <u>86</u> . That (I) (we) lost saw the deceased alive on <u>1/9</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22b. SIGNATURE <u>[Signature]</u> DEGREE | | 22c. DATE SIGNED <u>1/9/86</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MARTIN R. HORN</u> | | | | 22e. ADDRESS <u>Johns Hopkins Hosp., Baltimore</u> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 1-17-86 | | 23c. NAME OF CEMETERY OR CREMATORY GARRISON FOREST | | | 23d. LOCATION CITY OR TOWN COUNTY STATE OWING MILLS MARYLAND | | | | | | | |
| 24. FUNERAL DIRECTOR WM.C. MARCH F/H INC. 1101 E. NORTH AVENUE | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 16 1986 | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | | | | |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | | | |
|--|--|---------|---|------------------|------------------------------------|--|---|---|--------------------------------------|--|-----------------------|---|--|--|
| 1- FOR STATE REGISTRAR | | | 2a. DATE OF DEATH | | | | | | | 2b. HOUR | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | | MIDDLE | | LAST | | KNOWN ESTIMATED | | MONTH DAY YEAR | | | |
| Laurel Ann Ray | | | | | | | | | <input checked="" type="checkbox"/> | | 1 9 1986 | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | 7c. DATE PRONOUNCED DEAD | | 2d. HOUR | | |
| Female | | White | | May 14, 1966 | | 19 YRS. | | | | 1 9 1986 | | 6:10A | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| PA | | | U. S. A. | | | | | | Baltimore City, MD | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS | | | |
| Baltimore | | | 1300 St. Paul Street | | | | | Computer Type Setter | | | Bruswood | | | |
| 13a. STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| PA | | | Franklin | | Blue Ridge Summit | | <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | P. O. Box 216 | | | 99999 | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| Verne M. Ray, Jr | | | | | Dolores Foxel | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | | | | | | |
| No | | | 220-74-2509 | | | Summit, PA 17214 Dolores F. Ray, P.O. Box 216 Blue Ridge | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Smoke inhalation | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | 20. AUTOPSY? | | |
| | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | |
| | | | 5:52x 1 9 1986 | | | House fire | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION | | | CITY OR TOWN | | COUNTY STATE | | | |
| | | | house | | | 1300 St. Paul St. | | | Balto. | | MD. | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | TITLE (SPECIFY) | | | | | | DATE SIGNED | | | | | |
| Dennis F. Smyth, M.D. | | | M.D. Assistant | | | | | | 1/9/86 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | ADDRESS | | | | | | | | | | | |
| Dennis F. Smyth, M.D. | | | 111 Penn St. Balto., MD | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | COUNTY STATE | | | | |
| Burial | | | 13 Jan 86 | | New St. Joseph's | | | Emmitsburg | | Frederick MD | | | | |
| 24. FUNERAL DIRECTOR | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | |
| Skiles Funeral Home, Emmitsburg, MD 21727 | | | JAN 16 1986 | | | Julia Davidson-Rodriguez | | | | | | | | |

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(NR A15 NF (5))

20% COTTON FIBER

D.M.O.D. IN ALEXANDRIA



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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

0 1 4 7 7

REG. NO.

| | | | | | | | | |
|--|---|--|---|--|--|----------------------------------|-----------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| CHARLES I. REDDING Sr. | | | JANUARY 21, 1986 | | | 2:09 A | | |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | |
| Male | Black | JUNE 6 - 06 | 79 YRS. | | | IF UNDER 24 HRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| md. | U.S.A. | | | BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | JOHNS HOPKINS HOSPITAL | | | Truck Driver | | | Dairy | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE | | | | |
| md. | | Baltimore | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 2809 E. Biddle St. 21213 | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| Charles Redding | | | Sarah Dorian | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17 INFORMANT ADDRESS | | |
| No | | | 25-10-3625 | | | Agnes Redding 2809 E. Biddle St. | | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Cardiac pulmonary arrest | | 5 min. |
| DUE TO, OR AS A CONSEQUENCE OF (b) Cardiovascular collapse | | 3 hours. |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

| | | | | | |
|--|--|--|--|---|---|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/20, 19 86, to 1/21, 19 86, that (I) (we) last saw the deceased alive on 1/21, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Bruce Kone | | DEGREE | | 22c. DATE SIGNED 1/21/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bruce Kone, M.D. | | 22e. ADDRESS Johns Hopkins Hospital | | | |

| | | | |
|--|-----------|------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
| Burial | 1-25-86 | Mt. Calvary Cntry. | Cedar Hill A.A.Co. Md. |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE OF DEATH | 25b. REGISTRAR'S SIGNATURE |
| Randolph J. Collick 24316 Oliver St. | | JAN 25 1986 | |

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DHMH - 16 60M 7/B4
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | |
|--|-------------------------|---|--|---|-----------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) ROY - Redding | | | 2a. DATE OF DEATH MONTH 1 DAY 13 YEAR 86 | | 2b. HOUR 11:22 AM |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH 8 DAY 5 YEAR 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Maryland Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Construction | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 4525 Fairview Ave #A 21216 | |
| 14. FATHER'S NAME FIRST Charlie MIDDLE Redding LAST Redding | | 15. MOTHER'S MAIDEN NAME FIRST Matillie MIDDLE Redding LAST Redding | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 245-01 3514 | | 17. INFORMANT Elizabeth Redding ADDRESS 4525 Fairview Ave ER Admision Recor | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min 48 hrs |
| DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

| | | | |
|---|--|--|---|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a Chronic Obstructive Pulmonary Disease, Metabolic Acidosis | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/31 19 85 , to 1/13 19 86 , that (I) (we) last saw the deceased alive on 1/13 19 86 , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE Kevin L. Kouitz | DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/13/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kevin L. Kouitz | | 22e. ADDRESS University of Maryland Hospital | |

| | | | |
|---|-----------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 1/18/86 | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk. | 23d. LOCATION CITY OR TOWN Arbutus, Md. COUNTY STATE |
| 24. FUNERAL DIRECTOR NAME Wm C March F/H West ADDRESS 4300 Wabash Avenue | | 25a. DATE OF DEATH BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 16 1986 | |

020030

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

050030

UNRECORDED

NOTED



024084

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|------------------|--|---|---|------------------|--|----------------------------|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) James Reed | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 1-19 19 86 | |
| 3. SEX M | 4. RACE B | 5. DATE OF BIRTH MONTH DAY YEAR 11 22 28 | 6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN 57 YRS. | IF UNDER 24 YRS. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD 1-19 19 86 | 24. HOUR 8:25 a. m. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, | | MD | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 406 E. 21st Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 408 E. 21th STREET 21218 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM REED | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERTHA BUTLER | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. 216-22-4252 | | 17. INFORMANT JEAN BROOKS | | ADDRESS 408 E. 21th STREET | | 21218 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Alcoholism DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Dennis F. Smyth</i> | | | | TITLE (SPECIFY) Assistant | | | | MEDICAL EXAMINER | | DATE SIGNED 1-19-86 | |
| EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. | | | | ADDRESS 111 Penn St., Balto., Md. | | | | 21201 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 1-23-86 | | 23c. NAME OF CEMETERY OR CREMATORY GARRISON FOREST | | 23d. LOCATION CITY OR TOWN COUNTY STATE OWINGMILLS MARYLAND | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS WM.C.MARCH F/H INC. 1101 E. NORTH AVE. | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 22 1986 | | 25b. REGISTRAR'S SIGNATURE | | | |

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(VR A15 ME (15))

RECEIVED 100130

DAVID

WILL



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified 51 once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|---|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) WILLIAM R. REEDER, SR. | | | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 4, 1986 | | | 2b. HOUR AM | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR DEC. 14, 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY) 84 | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2108 MOSBY AVENUE 21207 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MAKER | | 12b. KIND OF BUSINESS OR INDUSTRY HATS | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY 21207 13c. CITY OR TOWN BALTIMORE | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 2108 MOSBY AVE. 21207 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOHN E. REEDER | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY LOUISE WINEKE | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- | | 17. INFORMANT ADDRESS 212-05-9437 WILLIAM R. REEDER, JR. BALTO., MD 21234 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of prostate DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 months | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Congestive Heart Failure | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/16/81 , 19 81 , to 4/16/86 , 19 86 , that I last saw the deceased alive on 4/30/86 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE [Signature] | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 1/6/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. NARAYEN, M.D. | | | | 22e. ADDRESS 3455 WILKENS AVE. 646-5055 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE) BURIAL | | 23b. DATE JAN. 7, '86 | | 23c. NAME OF CEMETERY OR CREMATORY HOLY ROSARY CEMETERY BALTIMORE, MARYLAND | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS WILLIAM E. JOHNSON 8521 LOCH RAVEN BLVD. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 8 1986 | | | | | |

BP

2012 CONJOINT

2012 CONJOINT



2012

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) AARON A. (Joseph) REEVES, Jr. | | | 2a. DATE OF DEATH MONTH DAY YEAR JAN 24 1986 | | 2b. HOUR 7:00 P.M. |
| 3. SEX MALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR 12 07 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Phila., Pa. | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman - Md. Pulman Co. - RR | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Md | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Catonsville | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Aaron A. Reeves, Sr. | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie --- McGeary | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. WW I 709-10-5324 | | 17. INFORMANT Catonsville, Md. 21228 Aaron A. Reeves, III - 38 Glenwood Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Aspiration pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1/24/86</u> to <u>1/24/86</u> , that (I) (we) last saw the deceased alive on <u>1/24/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 23a. SIGNATURE <u>Jose F. Fernandez</u> | | DEGREE | | 23b. DATE SIGNED 1/24/86 | |
| 23c. PHYSICIAN'S NAME (TYPE OR PRINT) Jose F. Fernandez | | 23d. ADDRESS St Agnes Hospital Balto, Md 21229 | | | |
| 23e. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment | | 23b. DATE 1/27/86 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Mausoleum - Baltimore, Maryland | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| 24. FUNERAL DIRECTOR NAME Sterling Funeral Estate, P.A. 736 Edmondson Ave.; Catonsville, Md. 21228 | | 25a. DATE REC'D. BY REGISTRAR JAN 28 1986 | | 25b. REGISTRAR'S SIGNATURE | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and laboratory (fill in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP _____

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MEMO

TO :

FROM :



DATE :

BY :

Baltimore City

X

10 Arthur Avenue - 21228

Baltimore City

Foreman - Baltimore Co. - 21228

Baltimore City

X

Baltimore City

A. (Boston)

10 of 100

10 of 100

730 Edmondson Ave., Baltimore, Md. 21228

Shelton Turner Estate, Inc.

115766 London & Co. Insurance-Baltimore, Maryland

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be called at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|----------|--|---------------------------------|------------------------------------|---|--|---|---|-----------------------------|--|
| 1- FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR | | |
| Williams | | | Reeves | | | 1 28 86 | | | 5:30 A.M. | | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 72 HRS. HOURS MIN. | |
| M | | B | | 5 5 14 | | 71 YRS. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | |
| VIRGINIA | | | U.S.A. | | | | | | BALTIMORE, CITY MD. | | |
| 10 CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BALTIMORE | | | LUTHERAN HOSPITAL | | | TRUCK DRIVER | | | | | |
| 13a. STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE | | |
| MARYLAND | | | | | BALTIMORE | | | | 1005 N. PAYSON ST. 21202 | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | |
| WILLIAM REAVES | | | CREASY | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | | 17. INFORMANT ADDRESS | | | | | |
| NO | | | 173-22-7081 | | | LOUISE ABRAHAM 1338 W. PIKE STREET | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| IMMEDIATE CAUSE (a) Cardiorespiratory Failure | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) bilateral pneumonia | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Rectosigmoid Cancer | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-24 1986, to 1/28 1986, that (I) (we) last saw the deceased alive on 1/28 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Raafat Z. Girgis | | | | | | DEGREE | | | 22c. DATE SIGNED 1/28/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Raafat x. Girgis | | | | | | 22e. ADDRESS Lutheran Hospital - Baltimore MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| BURIAL | | | 2-1-86 | | CHURCH CEMETERY | | | BALA CYNWYD PA. | | | |
| 24 FUNERAL DIRECTOR NAME WM.C.MARCH F/H INC. 1101 E. NORTH AVE. | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| | | | | | | JAN 28 1986 | | | Jana Gordon-Randall | | |

12-10-50

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1- STATE
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|-------------|--|--------|---|----------------------------|--|---|---|------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE KNOWN OF DEATH | | <input checked="" type="checkbox"/> MONTH | DAY | YEAR | 2b. HOUR |
| DONALD Blaine REIDER | | | | | 1 28 19 86 | | | | | AM |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| Male | White | 10 25 42 | | 43 YRS. | MONTHS | DAYS | HOURS | MIN. | 1 28 19 86 | 3:16 PM |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Pennsylvania | | U.S.A. | | | | Baltimore City MD | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | | van-front of 1816 N. Charles St. | | | | Food Service | | Balto. City | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | | | | | |
| Maryland | ----- | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 709 South Grundy St. 21224 | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| Ira Blaine Reider | | | | Catharine Handley | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | |
| Yes | | | | 1960-1964 | | Lynn A. Reider 709 S. Grundy St. 21224 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular disease</u> (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? | | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | |
| Ann M. Dixon, M.D. | | M.D. Assistant MEDICAL EXAMINER | | | | 1-29-86 | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | |
| Ann M. Dixon, M.D. | | 111 Penn St., Balto., MD 21201 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (CITY OR TOWN, COUNTY, STATE) | | | | |
| Cremation | | 1-31-86 | | Westview Memorial | | Westview, Balto. Co., Md. | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | | | |
| Charles S. Zeiler & Son Inc. | | | | 901 S. Conkling St. | | JAN 31 1986 | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Samuel R. Repp | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 9 1986 | | 2b. HOUR 3:30PM |
| 1. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 1 16 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Med. Ctr. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self Employed | 12b. KIND OF BUSINESS OR INDUSTRY Hardware Store | |
| 13a. STATE Maryland | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Dundalk | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 2709 North Point Rd. 21222 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Unknown | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. WW II 213-09-2798 | | 17. INFORMANT ADDRESS George L Buckless 1211 Hilldale Rd. 21237 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD and Diabetes</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1/2 Hour</u> <u>years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>October 30 1969</u> to <u>1-9-86</u> , that (I) (we) last saw the deceased alive on <u>10-23-85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Jose Ardaiz</u> | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1-10-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jose Ardaiz, M.D. P.A. | | 22e. ADDRESS 7838 Eastern Ave., Balto., Md. 21224 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 1-11-86 | 23c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | |
| 24. FUNERAL DIRECTOR NAME Duda-Ruck Funeral Home, Inc | | ADDRESS 7922 Wise Ave. Balto., Md. 21222 | | 25a. DATE REC'D. BY REGISTRAR JAN 13 1986 | |
| | | | | 25b. REGISTRAR'S SIGNATURE <u>John Davidson</u> | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed, within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be retained by the funeral director for use at the funeral home. Then please remove carbon papers. Page 4 should be detached for use at the funeral home. Page 5 should be retained by the funeral director. Page 6 should be retained by the funeral director. Page 7 should be retained by the funeral director. Page 8 should be retained by the funeral director. Page 9 should be retained by the funeral director. Page 10 should be retained by the funeral director. Page 11 should be retained by the funeral director. Page 12 should be retained by the funeral director. Page 13 should be retained by the funeral director. Page 14 should be retained by the funeral director. Page 15 should be retained by the funeral director. Page 16 should be retained by the funeral director. Page 17 should be retained by the funeral director. Page 18 should be retained by the funeral director. 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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|---|---|---------------------------------|--------------------------------|--|-----------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| FIRST MIDDLE LAST Joshua L. Reynolds | | | MONTH DAY YEAR 1 19 86 | | | 11:09AM | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | | | 7. IF UNDER 1 YEAR | | |
| Male | White | MONTH DAY YEAR APRIL 18, 1982 | 3 YRS | | | MONTHS DAYS HOURS MIN | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 9. BALTIMORE CITY OR COUNTY OF DEATH | 10. CITY OR TOWN OF DEATH | | | | | | |
| ILLINOIS | Baltimore City MD | Baltimore | | | | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | | | | |
| University of Maryland Hosp | --- | | | | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE | | | | |
| VIRGINIA | PRINCE WILLIAM | DALE CITY | YES XX NO | 14352 WRANGLER LANE 22193 | | | | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | | | |
| FIRST MIDDLE LAST LONNIE R. REYNOLDS | FIRST MIDDLE LAST MARILYN SUE RACKLEY | (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO ---- | | | | | | |
| 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | | | | | | |
| B19-72-2051 | LONNIE R. REYNOLDS WOODBRIDGE, VA22193 | | | | | | | |

| | | |
|--|------------------------------|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> | | |
| DUE TO, OR AS A CONSEQUENCE OF | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | (b) <u>Viral Pneumonitis</u> | |
| DUE TO, OR AS A CONSEQUENCE OF | | |
| (c) | | |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

Bronchopulmonary Dysplasia

| | | | |
|---|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| - | - | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) This hospital attended the deceased from 1/19/86 to 1/19/86, that (2) I saw the deceased alive on 1/19/86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (3) we (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED | |
| Michael A. Stoiko MD | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 1/19/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS | | |
| Michael A Stoiko MD | 225 Greene Street Balt Md | | |

| | | | |
|---|--|------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL (SEE REG.) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
| BURIAL | JAN. 25, '86 | ST. JOHN'S CEMETERY | GRANITE CITY, ILLINOIS |
| 24. FUNERAL DIRECTOR NAME ADDRESS | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | |
| WILLIAM E. JOHNSON 8521 LOCH RAVEN BLVD. | JAN 22 1986 Gina Davidson-Randall | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be delivered to the funeral director. He should be directed to file it with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 1B shows any injury, or other traumatic event, the medical examiner should be notified.

BP
DHMH - 16 60M 7/84
(VRA 15, 4)

1 M 26 11 02A
 Joseph A. Reynolds

File White

Baltimore City USA

University of Maryland Baltimore

Paul Henry Roberts
 1011 Pennsylvania

Geographical Institute

1111 1111 1111

Michael A. Reynolds
 2111 2111 2111

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | | | | | | | |
|--|--|---|--|--|--------------------------------------|--|--|---|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Raleigh Rhem | | | 2a DATE OF DEATH MONTH DAY YEAR 1/15/86 | | 2b HOUR 5³⁰ A M | | | | | | |
| 3 SEX M | | 4 RACE B | | 5 DATE OF BIRTH MONTH DAY YEAR 11 21 10 | | 6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 75 YRS | | IF UNDER 24 HRS HOURS MIN. 75 YRS | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | | | | |
| 10 CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN MARYLAND 13b COUNTY BALTIMORE | | | | | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS / ZIP CODE 2007 KENNEDY AVE. 21218 | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST WALTER RHAM | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PATSY PHILLIPS | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N O | | 16b SOCIAL SECURITY NO. 213-18-5376 | | 17 INFORMANT ADDRESS ALICE RHEM 2007 KENNEDY AVE. | | | | | | | |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory Failure

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b) Chronic Obstructive Pulmonary Disease

DUE TO, OR AS A CONSEQUENCE OF

(c) Sepsis, GI BleedAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Coronary Heart Failure

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>12/21</u> 19 <u>85</u> , to <u>1/15</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>1/15</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE <u>Timothy Sanett Murray</u> M.D. | | | | DEGREE M.D. | | 22c DATE SIGNED 1/15/86 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Timothy Sanett Murray, M.D. | | | | 22e ADDRESS Union Memorial Hospital | | | |

| | | | | | | | |
|--|--|----------------------------|--|--|--|---|--|
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b DATE 1-24-86 | | 23c. NAME OF CEMETERY OR CREMATORY CHURCH CEMETERY | | 23d LOCATION CITY OR TOWN COUNTY STATE KINSTON NORTH CARO. | |
| 24 FUNERAL DIRECTOR NAME ADDRESS WM.C.MARCH F/H INC. 1101 E. NORTH AVE. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 21 1986 | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) JENNIE RHODES | | | 2a. DATE OF DEATH MONTH DAY YEAR 01/ 14/ 1986 | | | 2b. HOUR 10:00P_M | | | |
| 3. SEX FEMALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 07 12 1893 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS 92 | | 7. UNDER 1 YEAR MONTHS DAYS 00 00 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Melchor Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) unknown | | 12b. KIND OF BUSINESS OR INDUSTRY unknown | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE 3314 Ellersli Avenue Baltimore, Md. 21218 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST unknown | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | (IF YES, GIVE WAR OR DATES) N/A | | 16b. SOCIAL SECURITY NO. 217-30-3415A | | 17. INFORMANT ADDRESS Baltimore, Md. 21218 Melchor N. Home 2327 N. Charles St. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Artery DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Dementia (b) Hypertension | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 1, 1985 to 1/14, 1986 , that (II) (we) lost saw the deceased alive on 1/14, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Neal M. Friedlander, M.D. | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/15/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Neal M. Friedlander, M.D. | | | 22e. ADDRESS 333 St. Paul Place, Suite 2A Baltimore, Md. 21202 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1/17/86 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat. Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md | | |
| 24. FUNERAL DIRECTOR NAME Wm C March F/H West | | | | | | ADDRESS 4300 Wabash Ave. | | 25a. DATE REC'D. BY REGISTRAR JAN 16 1986 | |
| 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | | |
|---|--|--|--|--|------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN M RHODE | | | 2a. DATE OF DEATH MONTH DAY YEAR 1/8/86 | | 2b. HOUR 9:21 P.M. | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 4, 1891 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS. | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 8. CITIZEN OF WHAT COUNTRY? U. S. A. | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | 10. CITY OR TOWN OF DEATH Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Grocer-Self Employed | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STATE Md. | | |
| 13b. COUNTY Balto. | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John G. Rhode | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Leightman | | 16. SOCIAL SECURITY NO. 215-03-8885 | | |
| 17. INFORMANT 1521 Woodcliff Rd. - Balto., Md. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardio - PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) Ventilator DEPENDANCE AFTER EPISODE OF PULMONARY EDEMA DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC OBSTRUCTIVE PULMONARY DISEASE 10 years | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 MIN 2 wk | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ACUTE RENAL FAILURE, METASTATIC CARCINOMA OF COLON, CARDIAC PACER FOR CARDIAC DYSARRHYTHMIAS | | | | | | |
| 19a. DATE OF OPERATION 12/24/85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED METASTATIC CARCINOMA OF COLON | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/16/1985 to 1/8/86 , that (I) (we) last saw the deceased alive on 1/8/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE Ed Chambers MD | | DEGREE MD | | 22c. DATE SIGNED 1/8/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. ED FORD CHAMBERS MD. | | 22e. ADDRESS 900 CATON AVE. BALTIMORE MD. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Jan. 11, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem. | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md. | | 24. FUNERAL DIRECTOR G. Truman Schwab 5151 Balto. Nat'l. Pike #21229 | | | | |
| 25a. DATE REC'D. BY REGISTRAR JAN 17 1986 | | 25b. REGISTRAR'S SIGNATURE J. W. MURPHY | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove cause of death. Page 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|---|---|--|-------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Averil M. Rice | | | 2a. DATE OF DEATH MONTH DAY YEAR January 29, 1986 | | 2b. HOUR 8AM M | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 11, 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1108 Wood Heights Avenue | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY Health Dept | |
| 13a. STATE Md | | 13b. COUNTY Balto. City | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Moses | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Mc Kelvey | | 16. STREET ADDRESS / ZIP CODE 1108 Wood Heights Avenue | | 17. ADDRESS Towson Md 21204 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 212-40-6067 | | 17. INFORMANT Hammond W. Rice, Jr | | 1553 Cottage Lane | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASKED - LVH - congestive heart failure - angina DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 20, 1986, to Jan 29, 1986, that (I) (we) last saw the deceased alive on Jan 20, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Dr. Donald W. Mintzer | | DEGREE MD. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/31/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Donald W. Mintzer | | 22e. ADDRESS 3009 Evergreen Avenue | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 02/01/86 | | 23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Parkville, Balto. Co. Md | |
| 24. FUNERAL HOME Burke-Henss Funeral Home, P.A. | | 25a. DATE REC'D. BY REGISTRAR FEB 03 1986 | | 25b. REGISTRAR'S SIGNATURE | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be returned to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be certified at once.

January 20, 1962

January 11, 1962

January 11, 1962

January 11, 1962

January 11, 1962

January 11, 1962

January 11, 1962

January 11, 1962

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January 11, 1962

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RAYMOND F. RICE | | 2a. DATE OF DEATH MONTH DAY YEAR 1-19-86 | | 2b. HOUR 1:48 M | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 11-8-42 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 43 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ind. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BOR. PECOIRA HOSP | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Ind. | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William F. Jarr | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Johnnie Rice | | 13e. STREET ADDRESS / ZIP CODE 1071 Elliott Dr. Balt. 21216 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. 214-40-8989 | | 17. INFORMANT MADEAN RICE | | ADDRESS 1071 ELLIOTT DRIVE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for death, and in Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) End stage renal disease DUE TO, OR AS A CONSEQUENCE OF (b) diabetic mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic heart disease PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Arteriosclerotic heart disease | | | | | | | |
| 19a. DATE OF OPERATION 1-13-86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED acute mitral regurgitation, chronic, moderate, aortic regurgitation | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-12-86 , 19 86 , to 1-19 , 19 86 , that (I) (we) last saw the deceased alive on 1-19 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Jon Sigelito, M.D. | | DEGREE | | 22c. DATE SIGNED 1-19-86 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. M. HIPOCITO, M.D. | |
| 22e. ADDRESS 4209 Frederick Ave. Balt., Md. 21229 | | 22f. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22g. ADDRESS | | 22h. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 01-23-86 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem. R. Co. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, A. A. Co. MARYLAND | |
| 24. FUNERAL DIRECTOR NAME BROWN THOMPSON F. H. | | ADDRESS 1915 W. BALTO. ST. | | 25a. DATE REC'D BY REGISTRAR JAN 22 1986 | | 25b. REGISTRAR'S SIGNATURE John Davidson-Randall | |

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|---|--|--|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Anne E. Richardson | | | 2a. DATE OF DEATH MONTH DAY YEAR January 7, 1986 | | | 2b. HOUR M | | | | |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR June 1, 1894 | | 6 AGE (IN YEARS LAST BIRTHDAY) 91 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | |
| 10 CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5112 Ardmore Way (Residence) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 5112 Ardmore Way 21206 | |
| 14 FATHER'S NAME FIRST MIDDLE LAST George Spence | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie Owens | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-07-4840D | | 17 INFORMANT ADDRESS Mrs. Inez Mae Drake 22 Sunnyview Drive 21131 | | | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 DAYS | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a CORONARY ARTERY DISEASE | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 19 70 to JANUARY 19 86 that (I) (we) last saw the deceased alive on 13 APRIL 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Dr. Dixon Hills | | | DEGREE MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 8 JAN 86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Dixon Hills M.D. | | | 22e. ADDRESS 3501 St. Paul St. Baltimore, Maryland | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE Jan. 10, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. Baltimore, Maryland | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 8 1986 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the portion of page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

016017

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

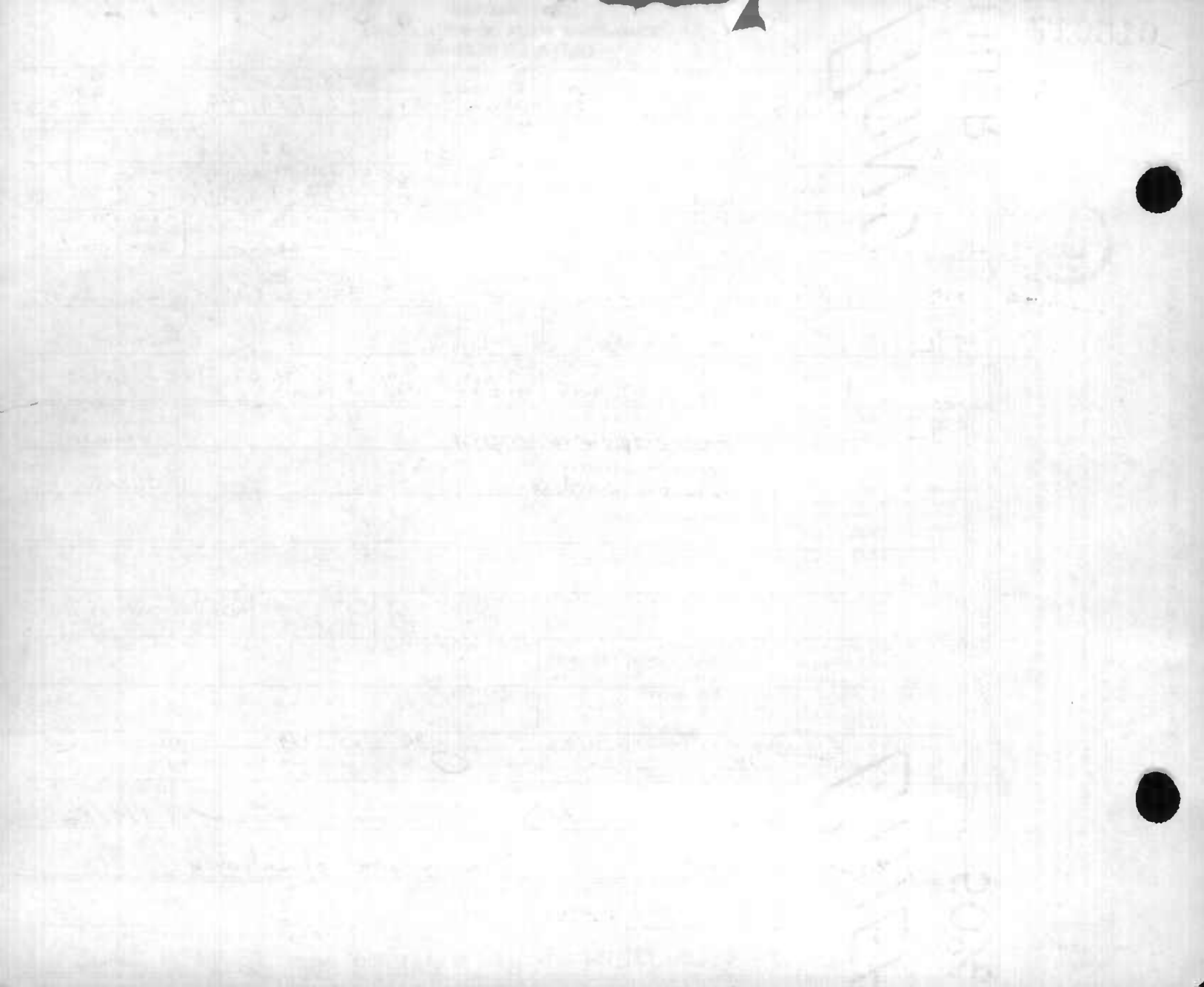
| | | | | | |
|---|--|--|--------------------------------------|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | 7 ⁴⁰ A.M. | |
| Dennis Lee Richardson | | 1/9/86 | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| M | B | MONTH DAY YEAR | 27 YRS | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Illinois | USA | | Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore City | Sinai Hospital | Manager | Restaurant | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
| MD | | Baltimore City | Baltimore | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 3824 W. Coldspring Lane 21215 |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 16. SOCIAL SECURITY NO. | | | |
| Curtis Lee | Lillian Farmer | 215-76-4445 | | | |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 17b. SOCIAL SECURITY NO. | 17. INFORMANT | | | |
| NO | 215-76-4445 | Hall, Lillian brother, Medical record | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: | | | | | 10 minutes |
| IMMEDIATE CAUSE (a) cardiopulmonary arrest | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (b) heroin overdose | | | | | 20 hrs |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| N/A | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | HOUR A.M. MONTH DAY YEAR | | | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | |
| AT HOME <input type="checkbox"/> NOT AT HOME <input type="checkbox"/> | | [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.] | | CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/8 1986, to 1/9 1986, that (I) (we) lost sight of the deceased alive on 1/9 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, (I) (did) not view the body after death.) | | 22b. SIGNATURE | | 22c. DATE SIGNED | |
| | | Norman A. Cohen MD | | 1/9/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| NORMAN A. COHEN | | Sinai Hospital of Baltimore | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION | COUNTY | STATE |
| Burial | 1/13/86 | Arbutus Memorial Park | Arbutus | | Md |
| 24. FUNERAL DIRECTOR | | | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE | |
| William C. March F/H West 4300 Wabash Avenue | | | JAN 13 1986 | [Signature] | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Page 1 and 2 should be filed in the funeral home within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



029027

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|---|--|--|--|--|--|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) ELOISE | | | 2a. DATE OF DEATH MONTH DAY YEAR 1-21-86 | | | 2b. HOUR 5:35 PM | | |
| 3. SEX FEMALE | | | 4. RACE BLACK | | | 5. DATE OF BIRTH MONTH DAY YEAR 6th 20 23 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MICHIGAN | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 6. AGE (IN YEARS LAST BIRTHDAY) 62 | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL | | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE, CITY | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABOR | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | | | 13b. COUNTY BALTIMORE | | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST HARRY ALVIN | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ADA PARSON | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 177 18-7158 | | | 17. INFORMANT ADDRESS THOMAS RICHARDSON 1737 HOMESTEAD ST. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Out Cell Lung Carcinoma - metastasis to brain, liver DUE TO, OR AS A CONSEQUENCE OF (c) Hemoptysis | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | |
| 19a. DATE OF OPERATION N/A | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR N/A | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N/A | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A | | |
| 22a. I certify that (I) (this hospital) attended the deceased from January 21, 1986 , to January 21, 1986 , that (I) (we) last saw the deceased alive on January 21, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE Melissa Beth Friedland M.D. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 22c. DATE SIGNED 1/21/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Melissa | | | | | | 22e. ADDRESS MELISSA FRIEDLAND M.D., UNION MEMORIAL HOSPITAL | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 1/28/86 | | | 23c. NAME OF CEMETERY OR CREMATORY MT. CALVARY CEM. | | |
| 24. FUNERAL DIRECTOR NAME WM. C. MARCH FUNERAL HOME | | | 24. FUNERAL DIRECTOR ADDRESS 1101 NORTH AVE. | | | 25a. DATE REC'D. BY REGISTRAR JAN 27 1986 | | |
| 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | | | | |

BP

750030

20% COTTON FIBER

WATKINS



024082

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01494

REG. NO.

| | | | | | |
|--|--------------|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FLORENCE RICHARDSON | | 2a. DATE OF DEATH MONTH DAY YEAR 1 20 86 | | 2b. HOUR 6:40 AM | |
| 3. SEX F | 4. RACE B | 5. DATE OF BIRTH MONTH DAY YEAR 11 25 29 | | 6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | | 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1217 WELLSBACH'S WAY | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 1217 WELLSBACH'S WAY 21224 | | 14. FATHER'S NAME FIRST MIDDLE LAST OBBIE TUNSTALL | |
| 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JENNIE PATTERSON | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 213-26-3104 | |
| 17. INFORMANT JOYCE KENNEDY | | ADDRESS 1614 NORMAL AVE | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) HYPOXIA DUE TO, OR AS A CONSEQUENCE OF (c) ACUTE PANCREATITIS | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 0 | | 1 week | | 2 weeks | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CHRONIC PANCREATITIS, ISCHEMIC CARDIOMYOPATHY, DM. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from 1/20 1986 to 1/20 1986, that (I) (we) lost saw the deceased alive on 1/20 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE C. Harter | | DEGREE MD | | 22c. DATE SIGNED 1/20/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. HARTER MD | | 22e. ADDRESS 4940 EASTERN AVE, BACT MD 20224 | | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL BURIAL | | 23b. DATE 1-23-86 | | 23c. NAME OF CEMETERY OR CREMATORY MOUNT AUBURN | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | | 24. FUNERAL DIRECTOR NAME ADDRESS WM. C. MARCH F/H INC. 1101 E. NORTH AVE. | | | |
| 25a. DATE REC'D. BY REGISTRAR JAN 22 1986 | | 25b. REGISTRAR'S SIGNATURE | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

UNCLASSIFIED

RECEIVED

Handwritten notes and bleed-through from the reverse side of the page, including the words "RECEIVED" and "UNCLASSIFIED".

031171

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | |
|---|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST <u>SELMA</u> MIDDLE <u>Selma</u> LAST <u>RICKLIN</u> <u>Ricklin</u> | | 2a. DATE OF DEATH MONTH <u>1</u> DAY <u>24</u> YEAR <u>88</u> | | 2b. HOUR <u>10th</u> AM |
| 3. SEX <u>F</u> FEMALE | 4. RACE <u>WHITE</u> | 5. DATE OF BIRTH MONTH <u>09</u> DAY <u>08</u> YEAR <u>12</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>69</u> YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MARYLAND</u> | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD. |
| 10. CITY OR TOWN OF DEATH <u>Baltimore</u> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Sumner Hospital of Baltimore</u> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>HOUSEWIFE</u> | 12b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u> |
| 13a. STATE <u>MARYLAND</u> | 13b. COUNTY <u>BALTIMORE</u> | 13c. CITY OR TOWN <u>BALTIMORE</u> | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE <u>2 STONEHENGE CIR., APT. 11</u> #21208 |
| 14. FATHER'S NAME FIRST <u>JOSEPH</u> MIDDLE <u></u> LAST <u>HERTZBACH</u> | | 15. MOTHER'S MAIDEN NAME FIRST <u>ANNA</u> MIDDLE <u></u> LAST <u>GOLD</u> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u> IF YES, GIVE WAR OR DATES | | 16b. SOCIAL SECURITY NO. <u>216-03-4581</u> | | 17. INFORMANT <u>MRS. RONA ENGEL</u> <u>3606 GARDEANVIEW CT. #21208</u> |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) Ischemic heart.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Long history of

DUE TO, OR AS A CONSEQUENCE OF

(c) Heart diseaseAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | |
|--|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/73</u> , 19 <u>86</u> , to <u>1/27</u> , 19 <u>88</u> , that (I) (we) last saw the deceased alive on <u>1/27</u> , 19 <u>88</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE <u>Friedrich J. Van den</u> | DEGREE <u>M.D.</u> | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>FRIEDRICH J. VAN DEN</u> | | 22e. ADDRESS <u>Sumner Hospital of Baltimore, Inc</u> | |

| | | | |
|---|-----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u> | 23b. DATE <u>1-26-86</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE HEBREW</u> | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>REISTERSTOWN BALTO. MD</u> |
| 24. FUNERAL DIRECTOR NAME <u>SOL LEVINSON & BROS., INC.</u> ADDRESS <u>6010 REISTERSTOWN RD., BALTO., MD 21215</u> | | 25a. DATE REC'D. BY REGISTRAR <u>2/1/86</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.



020049

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01496

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Laura Ricks | | | 2a. DATE OF DEATH MONTH DAY YEAR 1/10/86 | | | 2b. HOUR 9:30 P.M. | | | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 1/16/91 | | 6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS. | | 7. UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mississippi | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mt. Sinai N.H. | | | | 12a. USUAL OCCUPATION (TYPE OR BUSINESS FOR MOST OF WORKING LIFE) N/A | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD. | | | 13b. COUNTY | | 13c. CITY OR TOWN Balt. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME CARY | | | 15. MOTHER'S MAIDEN NAME MARY TAYLOR | | | 16. STREET ADDRESS / ZIP CODE 1723 CLIFVIEW AVE. 21213 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 218-52-1322 | | 17. INFORMANT THOMAS RICKS 3028 MOSHER STREET | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>COLONIC CANCER & ANEMIA</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>SEPT 85</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (the undersigned) attended the deceased from <u>1/12/81</u> , 19____, to <u>1/10/86</u> , 19____, that (I) (the undersigned) saw the deceased alive on <u>1/2/86</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Arthur M. Lebson</u> MD | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/13/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Arthur M. Lebson, M.D. | | | 22e. ADDRESS 3640 Fords Lane Balt., MD 21215 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 1-18-86 | | 23c. NAME OF CEMETERY OR CREMATORY CHURCH CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE ROCKY MOUNT N.C. | | |
| 24. FUNERAL DIRECTOR WM.C. MARCH F/H INC. 1101 E. NORTH AVE. | | | | | 25. DATE REC'D. BY REGISTRAR JAN 16 1986 | | 25b. REGISTRAR'S SIGNATURE | | |

MEDICAL CERTIFICATION

2/9

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



023106

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M
 BP
DHMH - 17
(VR A15 ME (5))

 1- FOR
STATE
REGISTRAR

 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | |
|--|---------|--|--|--|--|--|--|--|--|--|--|--|----|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH ESTIMATED XX 1-17 19 86 | | | | 2b. HOUR M | | |
| Tammie | | | | | | Rivers | | | | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS) (LAST BIRTHDAY) | | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD | | | | 2d. HOUR a. M | | |
| Female | Black | 1 30 63 | | 22 YRS. | | | | 1-18 19 86 | | | | 1:45 a. M | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| Maryland | | U.S.A. | | | | | | Baltimore City, | | | | | MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Baltimore | | 924 N. Duncan Street | | | | N/A | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | | | | |
| Maryland | | | | Baltimore | | | | 938 N. Duncan Street 21205 | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | |
| Richard Rivers | | Beaunita Ellerbe | | YES | | 220-76-5838 | | Beaunita Rivers 938 N. Duncan Street | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Manual Strangulation</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 1a. | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY est. HOUR A.M. MONTH DAY YEAR ? P.M. 1-17 19 86 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject was strangled | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 924 N. Duncan Street, Baltimore, Maryland | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Dennis F. Smyth M.D.</i> | | | | TITLE (SPECIFY) M.D. Assistant | | | | MEDICAL EXAMINER | | | | DATE SIGNED 1-18-86 | | |
| EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. | | | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 1/22/86 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md. | | | | |
| 24. FUNERAL DIRECTOR NAME March Funeral Homes 1101 East North Avenue | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 21 1986 | | 25b. REGISTRAR'S SIGNATURE | | | | | | |

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022112

1-
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|--|---|---|---|------------------------------------|---|--|---|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) Lois Rizzo | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 13 86 | | | 2b. HOUR 1:50 PM | | | | |
| 3. SEX F | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR 1 10 17 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD. | | | | |
| 10. CITY OR TOWN OF DEATH Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Key Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 8-B Glenwood 21221 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Harvey | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nora Baker | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | | | | | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) acute left transitional cell carcinoma of bladder DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 1/6/86 , 19 86 , to 1/10 , 19 86 , that (1) (we) lost saw the deceased alive on 1/10/86 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Brenda W. Cezar MD | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/13/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Brenda W. Cezar MD | | | | 22e. ADDRESS Francis Scott Key Medical Center | | | |

| | | | | | | | |
|--|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b. DATE 1/15/86 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME Anatomy Board | | | | ADDRESS Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR JAN 21 1986 | |
| | | | | 25b. REGISTRAR'S SIGNATURE K. Rindell | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate from the file. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

61130

RECEIVED

NOV 10 1964

UNCLAS

MAINTENANCE



036024

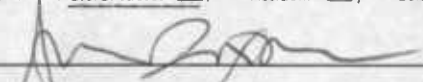
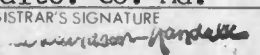
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF AN DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | |
|--|--|------------------|----------------|---|--|--|--|---|------------------------|---|--|---|--|--|-----------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST DAVID | | | MIDDLE EARL | | | LAST ROBERTSON, SR. | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 31 19 86 | | | 2b. HOUR 7:55 P.M. | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 11/13/44 | | 6. AGE (IN YEARS LAST BIRTHDAY) 41 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 31 19 86 | | | | | | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Md | | | | 13b. COUNTY -- | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3230 Keswick Road 21211 | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Van Buren Robertson | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hazel Roseanna Ball | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212 40 1570 | | | | 17. INFORMANT ADDRESS Charles B. Knott 615 W. 33rd Street 21211 | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | | | | | DATE SIGNED 2-1-86 | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | | ADDRESS 111 Penn St., Balto., MD 21201 | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | | 23b. DATE 02/04/86 | | 23c. NAME OF CEMETERY OR CREMATORY Westview Memorial Park | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE West View, Balto. Co. Md. | | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Burgee-Henss Funeral Home, 3631 Falls Rd 21211 | | | | | | | | 25a. DATE REC'D. BY REGISTRAR FEB 03 1986 | | | | 25b. REGISTRAR'S SIGNATURE  | | | | |

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

030013

READ MOTION XDR

DMO

CHIEF



011160

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | |
|---|---|--|---|---|
| 1. DECEASED NAME (LAST OR PRIOR) Skward FIRST Robinette MIDDLE | | | 2a. DATE OF DEATH MONTH January DAY 6 YEAR 86 2b. HOUR 8:55 PM | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH 5 DAY 11 YEAR 26 | | 6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 1 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (COUNTRY) West VA | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore Gen Hosp | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | 12b. KIND OF BUSINESS OR INDUSTRY Paint Factory |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 823 Clinton St 21225 | |
| 14. FATHER'S NAME FIRST BUD MIDDLE LAST Robinette | 15. MOTHER'S MAIDEN NAME FIRST FANNIE MIDDLE COONEY | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | 16b. SOCIAL SECURITY NO 235-42-4553 | 17. INFORMANT ADDRESS Sharon Conley Same as 13e | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary edema DUE TO, OR AS A CONSEQUENCE OF (c) pneumonia, wound infection, Renal failure | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE J. Griffin MD | | 22c. DATE SIGNED 1/7/86 | | |
| 22d. PHYSICIAN'S NAME (IF OTHER) | | 22e. ADDRESS 3001 South Hanover St. | | |
| 23a. BURIAL, CREMATION, REMOVAL Cremation | 23b. DATE 1/9/86 | 23c. NAME OF CEMETERY OR CREMATORY Westview Mem Park | 23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto Md | |
| 24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hwy Balto Md | | 25a. DATE REC'D. BY REGISTRAR JAN 10 1986 | 25b. REGISTRAR'S SIGNATURE W. Mason | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO FUNERAL DIRECTOR: After this certificate has been signed by a physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

93913 W 1100 2002

WATERFALL



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | |
|---|---|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) ANNIE R. ROBINSON | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 15, 1986 | | 2b. HOUR 2:45 a.m. |
| 3. SEX Female | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 11 25 10 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Md. | | | 13b. COUNTY | 13c. CITY OR TOWN Balto. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST James White | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Marshall | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 212-22-5121 | | 17. INFORMANT ADDRESS Alice Beckham Fremont, Calif. 36906 Bolind Terr. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) ADENOCARCINOMA OF THE LUNG DUE TO, OR AS A CONSEQUENCE OF (c) SEPSIS | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 30, 1985 to JANUARY 15, 1986 , that (x) (we) last saw the deceased alive on JANUARY 15, 1986 , and that in (xx) (our) opinion death occurred on the date and hour and from the causes stated above, (x) (we) (did) (do not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>Sera LaRondelle M.D.</i> | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sera LaRondelle, M.D. | | 22e. ADDRESS C/O MARYLAND GENERAL HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/18/86 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME Wm C March F/H West | | ADDRESS 4300 Wabash Ave | | 25a. DATE REC'D. BY REGISTRAR JAN 17 1986 | |
| | | 25b. REGISTRAR'S SIGNATURE | | | |

MEDICAL CERTIFICATION

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48
35
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the bottom papers. Pages 7 and 8 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10150

10150

020025

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) EDWARD MARTIN ROBINSON | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 13 1986 | | 2b. HOUR 8:05A M | |
| 3 SEX MALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR 12 16 05 | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10 CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Proprietor | | 12b. KIND OF BUSINESS OR INDUSTRY Tavern |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Robinson | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Delia Mannion | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 217-22-2177 | | 17. INFORMANT ADDRESS George Bromwell 1101 Pine Heights Ave. 21229 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) asgale DUE TO, OR AS A CONSEQUENCE OF (b) prob pulm embolus DUE TO, OR AS A CONSEQUENCE OF (c) cancer of pancreas s/p bypass procedure. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 min 2 days 3 wks |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a 0 | | | | | |
| 19a. DATE OF OPERATION 12/27/85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma pancreas | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/13 , 19 86 , to 1/13 , 19 86 , that (I) (we) last saw the deceased alive on 1/13 , 19 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did (did not) view the body after death.) | | | | | |
| 22b. SIGNATURE Rodney A. Lahren | | DEGREE PHYSICIAN | | 22c. DATE SIGNED 1/13/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rodney A. Lahren | | 22e. ADDRESS 900 Caton Ave | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/16/86 | | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | 23e. DATE REC'D. BY REGISTRAR JAN 16 1986 | | | |
| 24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. | | ADDRESS 4107 Wilkens Ave. | | 25b. REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by once.

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MADE IN U.S.A.

MADE IN U.S.A.

MADE IN U.S.A.



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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01503

REG. NO.

| | | | | | | | | | |
|---|--|---|--|--|--|---|--|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) ERNEST | | FIRST ROBINSON | | LAST | | 2a. DATE OF DEATH MONTH 1 DAY 28 YEAR 1986 | | TIME 11:15 AM | |
| 3. SEX MALE | | 4 RACE BLACK | | 5 DATE OF BIRTH MONTH 1 DAY 29 YEAR 1901 | | 6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | |
| 7a BIRTHPLACE (COUNTRY) Tennessee | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10 CITY OR TOWN OF DEATH Baltimore City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) N. Charles Gen. | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) contraction | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| 13a STATE md. | | 13b COUNTY | | 13c CITY OR TOWN City | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS / ZIP CODE 2025 ETTING ST. BALTO, Md. 21217 | |
| 14 FATHER'S NAME FIRST UNKNOWN MIDDLE LAST | | 15 MOTHER'S MAIDEN NAME FIRST UNKNOWN MIDDLE LAST | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b SOCIAL SECURITY NO. 213-05-3312 | | 17 INFORMANT Sarah Robinson 2025 ETTING ST. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular thrombosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0 | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 1/21 19 86 to 1/28 19 86 that (I) (we) lost saw the deceased alive on 1/28 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If (we) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE Marcos B. Galicia Jr. | | DEGREE | | 22c DATE SIGNED 1/28/86 | | | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) MARCOS B. GALICIA Jr. | | 22e ADDRESS 1206-08 W. North | | 22f ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 2-1-86 | | 23c. NAME OF CEMETERY OR CREMATORY mt. Zion | | 23d LOCATION CITY OR TOWN Balto. COUNTY md. STATE | | | |
| 24 FUNERAL DIRECTOR NAME William C. Brown | | ADDRESS 1206-08 W. North | | 25a. DATE REC'D. BY REGISTRAR FEB 05 1986 | | 25b REGISTRAR'S SIGNATURE Julia Swinton-Randall | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their plate remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 22 shows any injury, or other traumatic event, the medical examiner must be notified.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE FILED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01504

REG. NO.

| | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|---------|--|---|--|---|--|--|--|--|--|--------------------------------------|--|--|---|--------------------------------|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR | | | | | | | | | | 2b. HOUR | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST | | | | | | | | | | John Robinson, Jr | | | | | | | | | | 1-17 19 86 | | M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN | | 7. IF UNDER 1 YR. | | 7. IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | 7d. HOUR | | p. M | | | | | | | | | |
| male | | black | | 5 21 1928 | | 57 YRS. | | | | | | 1-17 19 86 | | 7:20 | | p. M | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | |
| N.C. | | | | U S A | | | | | | | | Baltimore City, | | | | MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | |
| Baltimore | | | | Maryland General Hospital | | | | Head Cook | | | | Restaurant | | | | | | | | | | | | | |
| 13a. STATE | | | | | | | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | 21217 | | | | | | | |
| Md | | | | | | | | | | | | Baltimore | | | | 2200 McCulloh Street 2nd Floor | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | | | | | | | | |
| John Robinson, Sr | | | | | | | | | | Cleo Johnson | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | | | | | | | | |
| Yes | | | | | | | | | | 244-36-8243 | | Clara Thorne 246 N. Hilton Street | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | | | | | | | | | | | |
| Chronic Obstructive Pulmonary Disease | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | | | | | | | TITLE (SPECIFY) M.D. Assistant | | | | | MEDICAL EXAMINER | | | | | DATE SIGNED 1-18-86 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. | | | | | | | | | | ADDRESS 111 Penn St., Balto., Md. | | | | | 21201 | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | | | | | | | | | 1/27/86 | | | | | Cedar Hill Cemetery | | | | | Anne Arundel Co Md | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | | | | | | ADDRESS | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| William C. March F/H West 4300 Wabash Avenue | | | | | | | | | | | | | | | JAN 24 1986 | | | | | | | | | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

01505

029152

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SILAS ROBINSON | | | 2a. DATE OF DEATH MONTH DAY YEAR 01 18 86 | | 2b. HOUR 12^{PM} |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 5 11 21 | | 6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina | 7b. CITIZEN OF WHAT COUNTRY? U.S. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD. | |
| 10. CITY OR TOWN OF DEATH Balto. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hosp. | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retail | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Md. | | 13b. COUNTY | 13c. CITY OR TOWN Balto. | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 17 W. Franklin St. 21201 |
| 14. FATHER'S NAME FIRST MIDDLE LAST Silas Robinson | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ester Palmer | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes | | 16b. SOCIAL SECURITY NO. 241-20-2156 | | 17. INFORMANT Ms. Ida Murray ADDRESS 1304 // Wirton St. Balto., Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke - (Cerebral Vascular Accident) DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) none APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month 20 + years | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: none | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/20 19 85 to 1/18 19 86 , that (I) (we) lost saw the deceased alive on 1/18 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Robert C. Greenwell Jr. | | DEGREE | | 22c. DATE SIGNED 1/18/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT C. Greenwell Jr. | | 22e. ADDRESS Mercy Hospital, Baltimore, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | 23b. DATE 1/22/86 | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME Anatomy | | Balto., Md. ADDRESS Board | | 25a. DATE REC'D. BY REGISTRAR JAN 28 1986 | 25b. REGISTRAR'S SIGNATURE John Trindon-Randall |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return page 3 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic, or other medical examination must be notified of once.

01147

037129

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

01506

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|--|--|--|---|--|-----------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) HUBERT VINCENT RODGERS | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 / 29 / 86 | | 2b. HOUR 4 30 P M | |
| 3. SEX MALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 07 19 16 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | 8. IF UNDER 24 HRS. HOURS MIN. | | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 10. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 12. CITY OR TOWN OF DEATH BALTIMORE | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOURS HOSPITAL | | 14. BALTIMORE CITY OR COUNTY OF DEATH CITY MD. | | |
| 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 15a. STATE Maryland | | 15b. COUNTY Baltimore | | 15c. CITY OR TOWN Baltimore | | |
| 16. FATHER'S NAME FIRST MIDDLE LAST Hubert A. Rodgers | | 17. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Thelma Wells | | 18. STREET ADDRESS / ZIP CODE 2028 Ruxton Ave 21216 | | |
| 19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 20. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219/07/4468 | | 21. INFORMANT ADDRESS Mabel Rodgers 2028 Ruxton Ave. 21216 | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CARDIO PULMONARY ARREST**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b) **METASTATIC CARCINOMA**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/23 , 19 86 , to 1/29 , 19 86 , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on 1/29 , 19 86 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (total) <input type="checkbox"/> saw the body after death. | | | | | | | |
| 22b. SIGNATURE JOHN SHAVENS | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/29/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN SHAVENS | | | | 22e. ADDRESS 518 CAMP MARR ROAD LINTHICUM, MD | | | |

| | | | | | | | |
|---|--|----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 2/3/86 | | 23c. NAME OF CEMETERY OR CREMATORY St. Luke's Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Reisterstown, Maryland | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Leroy O. Dyett 4600 Liberty Hgts. Ave. | | | | 25a. DATE REC'D. BY REGISTRAR FEB 04 1986 | | 25b. REGISTRAR'S SIGNATURE L. Davidson Rodell | |

100% COTTON FIBER

FEB 04 08

014086

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

01507

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

CHARLES E. ROGERS

2a. DATE KNOWN OF DEATH MATED ☒ MONTH DAY YEAR 19 1-6-86

2c. DATE PRONOUNCED DEAD 1-6-86 19 10:15 PM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Va

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

2000 blk. Harlem Avenue

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md

13b. COUNTY

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

121223
1908 W. Franklin Street

14. FATHER'S NAME

ROSCOE

MIDDLE

LAST

WHITE

15. MOTHER'S MAIDEN NAME

N/A

MIDDLE

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

Yes

16b. SOCIAL SECURITY NO.

226-30-3776

17. INFORMANT

ADDRESS

Luebertha Moye 1908 W. Franklin Street

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Gunshot wound of chest

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)
DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 1-6-86 1921c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
subject shot

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
on the ground

21f. LOCATION

2000 blk. Harlem Avenue Baltimore, Maryland

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opiniondeath resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE

Margarita A. Korell

TITLE (SPECIFY)

M.D. Assistant

MEDICAL EXAMINER

DATE SIGNED 1-7-86

EXAMINER'S NAME
(TYPE OR PRINT)

Margarita A. Korell, M.D.

111 Penn Street

ADDRESS

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

1/13/86

23c. NAME OF CEMETERY OR CREMATORY

Garrison Forest Vet

23d. LOCATION

Owings Mills

COUNTY

STATE

Md

24. FUNERAL DIRECTOR

NAME

ADDRESS

William C. March F/H West 4300 Wabash Avenue

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

JAN 10 1986

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 1 HOUR AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. TO FUNERAL DIRECTOR: PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. PAGE 6 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE: PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

REG. NO.

MEDICAL CERTIFICATION

DHMH - 16 50M 4/83
(VRA 15, 4)

008178

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- STATE REGISTRAR **RAMELLE T. ROLLEY**

| | | | | | |
|---|--|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) Ramelle T. Rolley | | | 2a. DATE OF DEATH MONTH 1 DAY 3 YEAR 86 HOUR 11:26 PM | | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH 7 DAY 17 YEAR 06 | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS | | IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY Secretary |
| 13a. STATE Maryland | | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Catonsville | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST Albert MIDDLE A. LAST Rolley | | | 15. MOTHER'S MAIDEN NAME FIRST Minerva MIDDLE Triplett LAST Triplett | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 212-01-8912 | | 17. INFORMANT J. Russell Riley ADDRESS 1111 Gary Drive Catonsville, MD. 21228 | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF (b) CVA | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | |
|---|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/3/86 to 1/3/86 , that (I) (we) lost saw the deceased alive on 1/3/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE Jimmy Sue | DEGREE M.D. | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED 1-3-86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JIMMY SUE, M.D. | | 22e. ADDRESS ST. AGNES HOSPITAL Baltimore, MD. | |

| | | | |
|--|----------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 1/7/86 | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery | 23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Baltimore Maryland |
| 24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, MD. 21228 | | 25. DATE REC'D. BY REGISTRAR JAN 6 1986 REGISTRAR'S SIGNATURE Wendy Anderson-Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.



Outstanding Account
No.

11/10/10

2010-11-10

021050

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | |
|---|---|--|---|---|---|
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DENNIS ROSENTHAL Sr. | | | 2a DATE OF DEATH MONTH DAY YEAR JANUARY 13, 1986 | | 2b HOUR 12:33am |
| 3 SEX Male | 4 RACE White | 5 DATE OF BIRTH MONTH DAY YEAR Nov. 19 1948 | | 6 AGE (IN YEARS LAST BIRTHDAY) 37 YRS | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b CITIZEN OF WHAT COUNTRY? USA | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10 CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Home Hospital | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Welder-Md. Port Administration | | 12b KIND OF BUSINESS OR INDUSTRY |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md. Balto. | | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Charles Wesley Rosenthal Sr. | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara I. Swinder | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-52-0455 | 17 INFORMANT ADDRESS Madeline Rosenthal 823 S. Lakewood Ave. 21224 | | | |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)
PART 1: DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

| | | | |
|--|---|---|--|
| 19a DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (this hospital) attended the deceased from JANUARY 12, 1986, to JANUARY 13, 1986, that (I) (we) lost saw the deceased alive on JANUARY 13, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | |
| 22b SIGNATURE <i>Paul Gormley</i> | | DEGREE MD | 22c DATE SIGNED 1/13/86 |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) PAUL GORMLEY MD | | 22e ADDRESS CHURCH HOSPITAL 100 N. BROADWAY, BALTIMORE, MD. 21231 | |

| | | | |
|--|---------------------|---|---|
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b DATE 1/16/86 | 23c NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | 23d LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland |
| 24 FUNERAL DIRECTOR NAME ADDRESS Connelly Funeral Home 300 Mace Ave. 21221 | | 25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE JAN 17 1986 <i>John David</i> | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate from the file and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

021020

RECEIVED OCT 10 1950

RECEIVED OCT 10 1950



023035

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | |
|--|--|------------------|---------------|---|--|---|--|---|-------------------|-----------------------------------|--|---|--|--|-----------------------|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST John | | | MIDDLE H. | | | LAST Ross, Sr. | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 1-19 1986 | | | 2b. HOUR 1:25 a.m. | | | | |
| 3. SEX Male | | 4. RACE Negro | | 5. DATE OF BIRTH MONTH DAY YEAR 1 14 1931 | | 6. AGE (IN YEARS) LAST BIRTHDAY 55 YRS. | | 7. IF UNDER 1 YR. MONTHS DAYS | | 7. IF UNDER 24 HRS. HOURS MIN. | | 2c. DATE PRONOUNCED DEAD 1-19 1986 | | | 2d. HOUR a.m. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 416 Normandy Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Laborer | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| 13a. STATE M.D. | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN BALTO. | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS 416 Normandy Ave 21229 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George B. Ross | | | | 15. MOTHER'S MAIDEN NAME MIDDLE LAST Mary Alice Mason | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes | | | | 16b. SOCIAL SECURITY NO. 1953-1436 | | | | 17. INFORMANT ADDRESS James Giles 416 Normandy Ave 21229 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>Ethanolism</u> | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Dennis F. Smyth</i> | | | | TITLE (SPECIFY) M.D. Assistant | | | | MEDICAL EXAMINER | | | | DATE SIGNED 1-19-86 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. | | | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY WATASATILL Church | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis Virginia | | | | | | | |
| 24. FUNERAL DIRECTOR NAME E. L. Phillips P.A. Funeral Home | | | | ADDRESS 1721 Monroe St. | | | | 25a. DATE REC'D. BY REGISTRAR 1 JAN 21 1986 | | | | 25b. REGISTRAR'S SIGNATURE <i>Anita Davidson-Randall</i> | | | | | | | |

MEDICAL CERTIFICATION



009068

DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. IF THE MEDICAL EXAMINER ALONG WITH THE FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

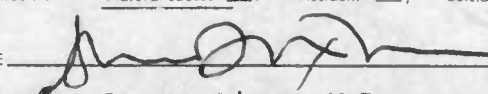
BP _____
DHMH - 17
(VR A15 ME (5))

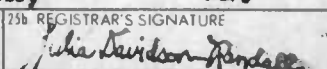
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01512

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|---|--|--|---|--|--|-----------------------------------|--|--|---|--|--|-----------------------|--|--|-----------------------|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MABEL | | | MIDDLE ROSS | | | LAST | | | 2a. DATE KNOWN OF DEATH ESTIMATED | | | MONTH 1 | | | DAY 3 | | | YEAR 19 86 | | | 2b. HOUR 8:47 P.M. | | | | | |
| 3. SEX Female | | | 4. RACE Negro | | | 5. DATE OF BIRTH MONTH DAY YEAR July 7, 1911 | | | 6. AGE (IN YEARS) LAST BIRTHDAY 74 YRS. | | | IF UNDER 1 YR. MONTHS DAYS | | | IF UNDER 24 HRS. HOURS MIN | | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 3 19 86 | | | 2d. HOUR 8:47 P.M. | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2210 Aiken St. | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House wife | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | |
| 13a. STATE Maryland | | | 13b. COUNTY | | | 13c. CITY OR TOWN Baltimore | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS 2514 E, Biddle St. 21213 | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Arthur Carter | | | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Hull | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | | | (IF YES, GIVE WAR OR DATES) | | | | | | 16b. SOCIAL SECURITY NO. 578-44-6865 | | | | | | 17. INFORMANT Virginia Taylor | | | | | | ADDRESS | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FATAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | | | | | | | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | | | DATE SIGNED 1-4-86 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | | | | | | | | | | ADDRESS 111 Penn St., Balto., MD 21201 | | | | | | | | | | | | | | | | | |

| | | | | | | | | | | | | | | | | | |
|--|--|--|--------------------------|--|--|--|--|--|--|--|--|---|--|--|-------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE Jan 7, 1986 | | | 23c. NAME OF CEMETERY OR CREMATORY Clevers Oak Church | | | 23d. LOCATION CITY OR TOWN Goldvien, Va. | | | COUNTY Va. | | | STATE | | |
| 24. FUNERAL DIRECTOR NAME Weldon R. Bailey, Goldensboro, Va. | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 8 1986 | | | 25b. REGISTRAR'S SIGNATURE  | | | | | |

0000

Female Negro July 2, 1911 74

Virginia U.S.A. X

House wife

Maryland Baltimore X 2514 E. Middle St.

Arthur Carter Ellis Hall

278-44-0805 Virginia Taylor No



Jan 2, 1980 Clevers Oak Church Golden, Va. Serial

035020

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) EDWARD F. ROTHEBERG | | | 2a DATE OF DEATH MONTH DAY YEAR 1-22-86 | | | 2b HOUR 10 30 PM | | | |
| 3 SEX MALE | | 4 RACE WT | | 5. DATE OF BIRTH MONTH DAY YEAR 10 28 09 | | 6 AGE (IN YEARS LAST BIRTHDAY) 77 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE MD | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10 CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY HOSP | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a STATE MARYLAND | | | | 13b COUNTY BALTIMORE | | 13c CITY OR TOWN BALTIMORE | | 13d INSIDE-CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST FRANK ROTHEBERG | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE WILSON | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | | 16b SOCIAL SECURITY NO. W.I. II 713 07 0855 | | 17 INFORMANT ADDRESS MRS ATELIA HIGH 3901 W. FOREST PK AVE 21207 | | | |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Sepsis**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) **Colon Carcinoma**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**48 hours****1 month**

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 1/20 , 19 86 , to 1/22 , 19 86 , that (I) (we) lost saw the deceased alive on 1/22 , 19 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. | | | | | | | |
| 22b SIGNATURE Bernita C. Taylor | | | | DEGREE MD | | 22c. DATE SIGNED 1/23/86 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Bernita C. Taylor MD | | | | 22e ADDRESS 611 South Charles St. Baltimore Md | | | |

| | | | | | | | |
|--|--|---------------------------|--|--|--|--|--|
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b DATE 2-3-86 | | 23c NAME OF CEMETERY OR CREMATORY GARRISON FOREST C.A. | | 23d LOCATION CITY OR TOWN COUNTY STATE BALTO. C. MD | |
| 24 FUNERAL DIRECTOR NAME ADDRESS JOSEPH L. RUSS 2222 W. NORTH AVE | | | | 25a DATE REC'D. BY REGISTRAR JAN 31 1986 | | 25b REGISTRAR'S SIGNATURE John Anderson-Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

10000

20% COTTON FIBER

MAILED

023071

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

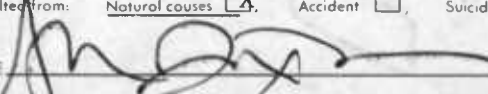
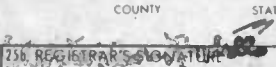
07/84
25M
 BP
DHMH - 17
(VR A15 ME (5))

 1- FOR
STATE
REGISTRAR

 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01514

REG. NO.

| | | | | | | | | | | | | | | | | | |
|--|--|------------------|----------------|---|--|--|--|---|------|--|--|---|--|--|-----------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST JAMES | | | MIDDLE ROUZER | | | LAST | | | 2a. DATE OF DEATH KNOWN OF ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 17 19 86 | | | 2b. HOUR M 11:15 A.M. | | |
| 3. SEX MALE | | 4. RACE Negro | | 5. DATE OF BIRTH MONTH DAY YEAR 11-11-33 | | 6. AGE IN YEARS (LAST BIRTHDAY) 52 YRS. | | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD 1 17 19 86 | | | 2d. HOUR M 11:15 A.M. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) M.D. | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 700 E. 41st St. | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Labor | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE M.D. | | | | 13b. COUNTY | | 13c. CITY OR TOWN BALTO. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 700 E 41st St. #21218 | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James Rowzer Sr. | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Willis | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-26-6289 | | 17. INFORMANT ADDRESS Ernestine Rowzer 1320 N Bond St | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Alcoholism</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY) M.D. Assistant | | | | MEDICAL EXAMINER | | | | DATE SIGNED 1-17-86 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | | ADDRESS 111 Penn St., Balto., MD 21201 | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (BY) Burial | | | | 23b. DATE 1-23-86 | | 23c. NAME OF CEMETERY OR CREMATORY Eastview Cem. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Betts Funeral Home | | | | ADDRESS 1129 N. Caroline St | | | | 25a. DATE RECEIVED BY REGISTRAR JAN 21 1986 | | | | 25b. REGISTRAR'S SIGNATURE  | | | | | |

032051

1000

WITNESS

RECEIVED



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 01515

FOR
STATE
REGISTRAR

REG. NO.

020029

| | | | | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--------------------------------|--|------------------|-----|------------|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR | |
| PEDRO | | | | | | RUBIO | | January 11, 1986 | | | | | 12:40P M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | |
| Male | | Black | | 1 MONTH 13 YEAR 1899 | | 86 YRS. | | MONTHS | | DAYS | | HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | |
| San Juan | | Puerto Rico | | | | Baltimore City | | | | | | MD. | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. TYPE OF WORK FOR MOST OF WORKING LIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| Baltimore | | Maryland General Hospital | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | | | | |
| Maryland | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 622 Pitcher St. 21217 | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | | | | | | | | | | |
| Martin | | Rubio | | Ambrosia | | Hernandez | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | |
| Yes | | WW II | | 215-03-2472 | | Gloria Rubio 4103 Wrentworth Ave. | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) | | Myocardial Infarction | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) Aortic Stenosis and Aortic Insufficiency | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | Congestive Heart Failure | | | | | | | | | | | | |
| (c) Atherosclerotic Cardiovascular Disease | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | |
| 22a. I certify that (this hospital) attended the deceased from January 9, 1986, to January 11, 1986, that (we) lost saw the deceased alive on January 11, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | | | | | | | | |
| MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | | |
| Johnathan Kushner M.D. | | c/o Maryland General Hospital | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | |
| Burial | | 1-16-86 | | Garrison Forest | | Owings Mills, Maryland | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | |
| Bailey-Douglass Funeral Home | | 1348 N. Calhoun St. | | JAN 16 1986 | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0500233



14 JAN 1961

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

031204

| | | | | | | | | | | |
|--|--|--|--|---|---|---|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Florence E. Russell | | | 2a. DATE OF DEATH MONTH DAY YEAR January 26, 1986 | | | 2b. HOUR 8:05P M | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR October 8, 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 84 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Roland Park Health Care Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY Education | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Ohio | | | 13a. CITY OR TOWN Franklin | | 13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13c. STREET ADDRESS / ZIP CODE 2830 N. West Blvd. 43221 | | | |
| FATHER'S NAME FIRST MIDDLE LAST Frank M. Nicodouns | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julian Hammer | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (S. NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | 16b. SOCIAL SECURITY NO. 190-36-5188A | | 17. INFORMANT JoAnn Linck | | | | ADDRESS 1228 Pleasant Valley Drive Catonsville, MD. 21228 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) CHF DUE TO, OR AS A CONSEQUENCE OF (c) 4 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Second | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a | | | | | | | | | | |
| 9a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1985 , 19 1/26 , 19 86 , that (I) (we) last saw the deceased alive on 1/26/86 , 19 86 , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Richard Z. Diamond | | | | | | DEGREE MD | | 22c. DATE SIGNED 1/27/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard Diamond M.D. | | | | | | 22e. ADDRESS 3547 Chestnut Avenue, Baltimore, MD. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | 23b. DATE 1/28/86 | | 23c. NAME OF CEMETERY OR CREMATORY Westview Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville MD. | | | |
| 24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, MD. 21228 | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE John F. Funder | | |

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MAINTAINED

RECEIVED ACTION 2/12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and advised.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--------|---|------------------|---|---|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | January 25, 1986 | | 10:30 AM |
| Frances W. Russell | | 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | |
| Female | | Cauc. | | April 11, 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Missouri | | USA | | Balto. City | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Balto. City | | 830 W. 40th street | | Housewife | | Home | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| Florida | | Palm Beach | | Boco Raton | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 13e. STREET ADDRESS / ZIP CODE | | 13f. STREET ADDRESS / ZIP CODE | |
| Frank | | Jennie | | 600 S. Ocean Blvd. 33432 | | 21211 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| No | | 264-80-3188 | | J. Arthur Russell | | 830 W. 40th Balto. Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 MONTH</u> |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MYOCARDIAL INFARCT</u> | | | | | | | <u>1 MONTH</u> |
| (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u> | | | | | | | <u>YEARS</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>HYPERTENSION CHRONIC RENAL INSUFFICIENCY CHRONIC DEMENTIA</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <u>24 JAN 1986</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE <u>Dr. John Macgibbon</u> | | DEGREE <u>MD</u> | | 22c. DATE SIGNED <u>25 JAN 1986</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | |
| Dr. John Macgibbon | | 101 W Read street Medical Arts Bldg. Balto. Md. 21201 | | Removal | | 1-25-86 | |
| 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | 24. FUNERAL DIRECTOR NAME ADDRESS | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | |
| Boco Raton Mausoleum | | Boco Raton, Florida | | Schimunek 3331 Brehms Lane Balto. Md. 21213 | | JAN 28 1986 <u>John Schimunek</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corpse slippers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | 86 01518 | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| FIRST MIDDLE LAST William A. Ryan, Jr. | | | | 1 2 86 | | 3 12 | | 3 0 | | A M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | |
| M | | B | | MONTH DAY YEAR 2 22 15 | | 70 YRS | | MONTHS DAYS | | HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| S.C. | | USA | | | | Baltimore at MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Baltimore | | Hutcheson Hospital | | | | Retired | | Bethlehem Steel | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | |
| Md | | | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 3302 Clifton Ave Apt 3 21216 | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| FIRST MIDDLE LAST William Ryan, Sr | | | | FIRST MIDDLE LAST Mable Logan | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | | |
| No | | | | 249-09-4199 | | Lucille Ryan 3302 Clifton Ave | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.0 | | | | | | | | | | | | | |
| <u>CEREBROVASCULAR ACCIDENT</u> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY STATE | |
| | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/8</u> 19 <u>85</u> to <u>1/2</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12/8/86</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | DEGREE | | 22c. DATE SIGNED | | | |
| Edward Jay Woy | | | | | | | | | | 1/2/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | 22e. ADDRESS | | | | | |
| Edward Woy | | | | | | | | 6408 B E 11th Ave S.W. Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | | | 1-7-86 | | Cedar Hill Cemetery | | | | Apopka, Apopka Co Md | | | |
| 24. FUNERAL DIRECTOR NAME | | | | 24b. ADDRESS | | | | 25a. DATE | | 25b. REGISTRAR'S SIGNATURE | | | |
| Wm. C. Markle F.H. | | | | 4300 Walkers | | | | JAN 1 1986 | | | | | |

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|---|---|----------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RUPERT H. SALE | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 19 1986 | | 2b. HOUR 9 00P M | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR MAY 29 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Route Salesman | | 12b. KIND OF BUSINESS OR INDUSTRY Sealtest | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Catonsville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John L. Sale | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora Lee Jennings | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | |
| 16b. SOCIAL SECURITY NO. 215-10-8113 | | 17. INFORMANT ADDRESS Edward J. Sale Same as # 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA OF THE LUNG DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YEARS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a MYOCARDIAL INFARCT SECONDARY TO ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE | | | | | | | |
| 19a. DATE OF OPERATION — | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from 1-19-86 to 1-19-86 , that (X) (we) last saw the deceased alive on 1-19-86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Steven H. Pearlman | | DEGREE M.D. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/20/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEVEN H. PEARLMAN | | 22e. ADDRESS ST. AGNES HOSPITAL 900 S. CATON AVE | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/23/86 | | 23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Maryland | |
| 24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke | | | | 25a. DATE REC'D. BY REGISTRAR JAN 21 1986 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |
| 1630 Edmondson Avenue, Catonsville, MD. 21228 | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2, and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

036039

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

01520

REG. NO.

| | | | | | | | | | | | |
|--|--|---|---|---|-------------------------------------|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Michael Sampson</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>1-30-86</i> | | 2b. HOUR MIN. <i>10 41 AM</i> | | | | | | |
| 3. SEX <i>M Male</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>May 2, 1907</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>78</i> | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | 8. IF UNDER 24 HRS. | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i> | | 9b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City, MD.</i> | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Lutheran Hospital</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Maintenance</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Bal Co School Bd</i> | | |
| 13a. STATE <i>Maryland</i> | | 13b. COUNTY <i>-----</i> | | 13c. CITY OR TOWN <i>Baltimore</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE <i>203 S Ann Street 21231</i> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Dock Sampson</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Rebecca Hammond</i> | | | | 16. ADDRESS <i>20722</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>413-10-2349</i> | | 17. INFORMANT ADDRESS <i>Mary K Glorius 3601 43rd Ave Brentwood Md</i> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF <i>Ischemic heart disease</i> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF <i>Myocardial infarction</i> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <i>Myocardial infarction</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Myocardial infarction</i> | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>2/16 1986</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2/16</i> 19 <i>86</i> to <i>12/30</i> 19 <i>86</i> , that (I) (we) lost saw the deceased alive on <i>12/30</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>[Signature]</i> | | | | | | | | | | 22c. DATE SIGNED <i>1-30-86</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Moges Gebremanan</i> | | | | | | | | | | 22e. ADDRESS <i>Lutheran Hospital Baltimore Md.</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>02/03/86</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Oaklawn Cem</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Md.</i> | | | | | |
| 24. FUNERAL DIRECTOR NAME <i>Dippel Funeral Homes, Inc.</i> | | | | | | 25a. DATE REC'D. BY REGISTRAR <i>FEB 03 1986</i> | | | | | |
| 27110 Belair Road Baltimore, Md. 21206 | | | | | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | |

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01521

REG. NO.

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|---|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Ruby B. Samsel | | | 2a. DATE OF DEATH MONTH 1 / DAY 20 / YEAR 86 | | 2b. HOUR 12:57 M |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH March / DAY 27 / YEAR 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. MONTHS 7 DAYS 18 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN A NURSING HOME, GIVE STREET ADDRESS) Union Memorial Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md 13b. COUNTY -- 13c. CITY OR TOWN Baltimore | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 1301 W. 42nd Street 21211 |
| 14. FATHER'S NAME FIRST John L. MIDDLE Stone LAST Stone | | | 15. MOTHER'S MAIDEN NAME FIRST Dora MIDDLE Wolf LAST Wolf | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 212 09 7624 | | 17. INFORMANT ADDRESS Robert L. Samsel same | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

CARDIAC ARRESTAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHConditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **BACTERIAL SEPSIS**

DUE TO, OR AS A CONSEQUENCE OF

(c) **RENAL FAILURE**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a

MEDICAL CERTIFICATION

| | | | | | |
|---|--|--|--|---|--|
| 19a. DATE OF OPERATION 1/19/86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Abscess formation | | 20a. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/19/86 19____ to 1/30/86 19____, that (I) (we) last saw the deceased alive on 1/20/86 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE B. Szura | | DEGREE | | 22c. DATE SIGNED 1/20/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. Szura, M.D. | | 22e. ADDRESS Union Memorial Hospital | | | |

| | | | |
|--|------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 01/23/86 | 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | 23d. LOCATION CITY OR TOWN COUNTY STATE Frederick, Fred. Co. Md |
| 24. FUNERAL DIRECTOR NAME Burgee-Henss Funeral Home | | ADDRESS 3631 Falls Rd | 25a. DATE REC'D. BY REGISTRAR JAN 24 1986 |
| | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

01522

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|--|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) ASSUNTA SANTASTEFANO | | | 2a. DATE OF DEATH MONTH DAY YEAR January 17, 1986 | | 2b. HOUR M |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 15, 1888 | 6. AGE (IN YEARS LAST BIRTHDAY) 97 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6601 Fair Oaks Avenue | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 6601 Fair Oaks Avenue 21214 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Varrato | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (Unknown) | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-74-9297 | 17. INFORMANT ADDRESS Mr. Ralph H. Santa 1017 St. Albans Road | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cause of colon DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) misdiagnosed cancer DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 mo. |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: none | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/85 , 19____, to 1/17/86 , 19____, that (I) (we) lost saw the deceased alive on 12/20/85 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE David S. Shear | | DEGREE MD | 22c. DATE SIGNED 1/17/86 | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) David S. Shear, M.D. | | 22e. ADDRESS 660 Kenilworth Drive | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 1/21/86 | 23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck, Inc. 5305 Harford Road 21214 | | 25a. DATE REC'D. BY REGISTRAR JAN 21 1986 | | | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove costs to burial, cremation, or removal of the body from the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01523

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|--|---|---|--|---|---|
| 1 DECEASED NAME (TYPE OR PRINT) MARCELLA SAUNDERS | | | 2a. DATE OF DEATH MONTH DAY YEAR 01 11 86 | | | 2b. HOUR 8:20P M | |
| 3 SEX FEMALE | | 4 RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 08-13-13 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD. | |
| 10. CITY OR TOWN OF DEATH city | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOURS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 13a. STATE MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST JOHN H. SAUNDERS | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERTHA GERTRUDE BROWN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. 217-09-7742 | | 17. INFORMANT ADDRESS JEANETTE TURNER COLEMAN | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE (b) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 01/5 86 01/11 86 | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 1/11 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Kuang-Yen Huang M.D. | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/11/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) KUANG-YEN HUANG | | 22e. ADDRESS BON Secours Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 01-16-86 | | 23c. NAME OF CEMETERY OR CREMATORY MT. CALVARY | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | |
| 24 FUNERAL DIRECTOR NAME BROWN THOMPSON F.H. | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 1913 W. BALTO. ST. JAN 16 1986 | | | |

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called and advice obtained.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|---|---|-----------------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOSEPHINE SAVICK | | | 2a. DATE OF DEATH MONTH DAY YEAR January 3, 1986 | | 2b. HOUR a 8:00 m | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 13, 1915 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 601 Wyanoke Ave., # 107 | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress | | 12b. KIND OF BUSINESS OR INDUSTRY Bakery | |
| 13a. STATE MD | | 13b. COUNTY | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE 601 Wyanoke Ave., 21218 | | 14. FATHER'S NAME FIRST MIDDLE LAST Jerome Savickas | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Torzka | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 077 24 9676 | | 17. INFORMANT ADDRESS Bruce Rice, 711 Hollen Rd., 21212 | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Cardio Vascular Disease with arterial hypertension DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (the hospital) attended the deceased from 2/25/80 , 19____, to 7/5/84 , 19____, that (1) (we) lost saw the deceased alive on 7/5/84 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated 22b. SIGNATURE Thomas L. Worsley DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> 22c. DATE SIGNED 1/3/86 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Thomas L. Worsley, MD | | 22e. ADDRESS 6505 York Road, Balto., MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/6/86 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, MD | |
| 24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212 | | | | 25a. DATE REC'D. BY REGISTRAR JAN 6 1986 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

BP

008163

THE PHINNEY

VIC.

January 6, 1918

For 12

with

For 12, 1918

to

New Jersey

USA

X Baltimore City

Baltimore

West Waverly Ave., 107

at the

Baker

MD

Balto.

x

501 Waverly Ave., 111

James

Swick

Josephine

John

no

County of Prince Georges, 711 Hollin Rd., 21515

Handwritten note:
The above is a copy of the original
document and is not to be used for
any other purpose.

Handwritten: 11/15/18

Handwritten: 11/15/18

Mr. Thomas E. Murphy, 111 York Road, Balto., MD

111 York Road, Balto., MD

Harry W. Banks, 111 York Road, Balto., MD

111 York Road, Balto., MD 21215

Clara Banks,

MD

013029

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01525

FOR
1. STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|--|--|---|--|---|----------------------------------|---|---|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Margaret Mary Scannello | | | 2a. DATE OF DEATH MONTH DAY YEAR 01 08 86 | | | 2b. HOUR 7 ⁴⁰ a.m. | | | | | |
| 3. SEX Female | | 4. RACE Cauc. | | 5. DATE OF BIRTH MONTH DAY YEAR 02 20 11 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY - | | | |
| 13a. STATE Maryland | | | 13b. COUNTY Anne Arundel | | 13c. CITY OR TOWN Glen Burnie | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 200 Vernon Ave 21061 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST unknown | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 220 14 5343 | |
| 17. INFORMANT FIRST MIDDLE LAST Patrick C. Scannello | | | ADDRESS 114 Vernon Ave. 21061 | | | | | | | | |

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) pulmonary embolism
DUE TO, OR AS A CONSEQUENCE OF
(b) pulmonary fibrosis / bronchiectasis
DUE TO, OR AS A CONSEQUENCE OF
(c) Aspergillosis

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
minutes
years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Aspergillosis

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 19a. DATE OF OPERATION none | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N/A | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |

22a. I certify that (I) (this hospital) attended the deceased from 12/6, 1985, to 7/8, 1986, that (I) (we) lost
saw the deceased alive on 7/8, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death.

| | | | | | | | |
|---|--|--------------|--|--|--|----------------------------|--|
| 22b. SIGNATURE Matthew G. Wagner MD | | DEGREE MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/8/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Matthew G. Wagner MD | | | | 22e. ADDRESS 301 St Paul Pl. Mercy Hosp. Baltimore 21202 | | | |

| | | | | | | | |
|--|--|----------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-11-86 | | 23c. NAME OF CEMETERY OR CREMATORY Saint Stanislaus | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. City Md. | |
| 24. FUNERAL DIRECTOR NAME Raymond C. Fink | | | | ADDRESS Glen Burnie, Md | | 25a. DATE REC'D. BY REGISTRAR JAN 9 1986 | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE Julia Davidson | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate from page 1 and 2 should be buried with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

BP

028033

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by a physician who has attended the deceased within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | | |
|--|--|--|-------------|---|--|--|--|--|--|---|--|----------------------------|--|
| 1. FOR STATE REGISTRAR | | | 2. REG. NO. | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| FIRST MIDDLE LAST | | | | | | MONTH DAY YEAR | | | | HOUR MIN. | | | |
| 3. SEX | | | | | | 4. RACE | | | | 5. DATE OF BIRTH | | | |
| Female | | | | | | White | | | | April 20 1926 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| Auburn, Pa. | | | | | | USA | | | | BALTIMORE CITY OR COUNTY OF DEATH | | | |
| 10. CITY OR TOWN OF DEATH | | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF BUSINESS OR WORKING LIFE) | | | |
| Baltimore | | | | | | Francis Scott Key Medical Center | | | | Housewife | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13b. INSIDE CITY LIMITS? | | | | 13c. STREET ADDRESS / ZIP CODE | | | |
| 13a. STATE | | | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | |
| Maryland | | | | | | Baltimore | | | | 2635 Greenmount Ave. 21218 | | | |
| 14. FATHER'S NAME | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST | | | | | | FIRST MIDDLE LAST | | | | | | | |
| Harrison Kerschner | | | | | | Anna Dissinger | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | |
| No | | | | | | 192 20 7201 | | | | C Cedarburg Court | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| IMMEDIATE CAUSE (a) | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| Cardiopulmonary Arrest | | | | | | DAY 0 CARDIAC INFARCTION | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| | | | | | | SEPSIS | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| | | | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 22, 19 86, to Jan 23, 19 86, that (I) (we) lost saw the deceased alive on Jan 23, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death. | | | | | | | | | | 22c. DATE SIGNED | | | |
| 22b. SIGNATURE | | | | | | | | | | 22d. ADDRESS | | | |
| SE VANCE | | | | | | | | | | Fskinc | | | |
| 23a. BURIAL, CREMATION, REMOVAL (CHECK ONE) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Removal | | | | 1/23/86 | | Detwiler & Stabingas F.H. | | | | 17992 Schuykill Haven, Penna. | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | | | 25b. REGISTRAR'S SIGNATURE | |
| Bruzdzinski Funeral Home PA 1407 Old Eastern Ave. | | | | | | JAN 24 1986 | | | | | | | |

BP

038033

Henry J. Conrad

April 20 1958

USA

100 20 1901

100 20 1901

100 20 1901

100 20 1901

100 20 1901

010006

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01527

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1- DECEASED NAME (TYPE OR PRINT) JOHN WILLIAM SCHELLENSCHLAGER | | | 2a. DATE OF DEATH MONTH DAY YEAR January 2, 1986 | | | 2b. HOUR 9:00 A.M. | | | |
| 1. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 25, 1926 | | 6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS | | # UNDER 1 YEAR MONTHS DAYS 9 MONTHS 0 DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Med. Ctr. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Meat Manufact. | | 12b. KIND OF BUSINESS OR INDUSTRY Esskay Co. | |
| 13a. STATE Maryland | | 13b. COUNTY Anne Arundel | | 13c. CITY OR TOWN Pasadena | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE Pasadena, 21122 141 Faywood Ct./Apt.-F. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST - Schellenschlager | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy Schellenschlager | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) - - - | | 17. INFORMANT ADDRESS 141 Faywood Ct./Apt. F. Pasadena, Md. 21122 | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MIDDLE DAY YEAR
P.M. **N/A** 19

21c. HOW INJURY OCCURRED (ENTER PORTION OF INQUIRY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from **January 2, 1986** to **Jan. 2, 1986**, that (I) (we) last saw the deceased alive on **Jan. 2, 1986** and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

Benjamin A. de Guzman, M.D.ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

BENJAMINA. de GUZMAN**1730 Crain Highway, South
Glen Burnie, Md. 21061**

| | | | | | | | |
|--|--|----------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Jan. 6, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Howard Co., Maryland | |
| 24. FUNERAL DIRECTOR NAME McCully Funeral Home/ Pasadena, Md. 21122 | | | | 25a. DATE REC'D. BY REGISTRAR JAN 8 1986 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove section 25b. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

010130

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01528

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | |
|--|--|---|---|---|
| 1 DECEASED NAME (TYPE OR PRINT) Lena Schiff | | 2a. DATE OF DEATH MONTH DAY YEAR 1 6 86 | | 2b. HOUR 2:25 AM |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 07 15 08 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ITALY | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANCIS SCOTT KEY CENTER | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | 12b. KIND OF BUSINESS OR INDUSTRY AT HOME |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS / ZIP CODE 3515 GOUGH ST. #21224 |
| 14. FATHER'S NAME FIRST MIDDLE LAST HARRY GENOVESE | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CONCETTA LAMARINTINI | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 213-16-0555 | | 17. INFORMANT RITA SHEA ADDRESS 118 S. EATON ST. BALTO., MD 21224 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c) mitral stenosis | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/22/85 , 19 85 , to 1/6 , 19 86 , that (I) (we) last saw the deceased alive on 1/6 , 19 86 , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did not view the body after death. | | | | |
| 22b. SIGNATURE Coburn Peterson MD | | DEGREE | | 22c. DATE SIGNED 1/6/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Coburn Peterson | | 22e. ADDRESS FRANCIS SCOTT KEY CENTER - BALTO., MD | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE JAN. 7, 1986 | 23c. NAME OF CEMETERY OR CREMATORY KNESSETH ISRAEL ANSHE | 23d. LOCATION (CITY OR TOWN) COUNTY STATE KOLK BALTIMORE COUNTY MARYLAND |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. | | ADDRESS 6010 REISTERSTOWN RD. BALTO, MD 21215 | | 25. DATE REC'D. BY REGISTRAR JAN 8 1986 |
| | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP



038046

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01529

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|---|--|--|--|----------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) Benjamin Schindler | | | 2a. DATE OF DEATH MONTH DAY YEAR 01 27 86 | | | 2b. HOUR 1:25 P.M. | | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR MAR. 10, 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) EMPLOYEE | | 12b. KIND OF BUSINESS OR INDUSTRY BALTIMORE CITY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | | 13b. COUNTY BALTIMORE | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS 2804 MANHATTAN AVE. 21215 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST NATHAN SCHINDLER | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH UNKNOWN | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | | 16b. SOCIAL SECURITY NO. 220-09-5087 | | 17. INFORMANT MRS. MARGARET SCHINDLER ADDRESS 2804 MANHATTAN AVE. BALTO., MD 21215 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerotic Coronary Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 1/2 hours many years | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Aortobifemoral Bypass, SLP Right lobectomy for CA, pulmonary emphysema | | | | | | | | | |
| 19a. DATE OF OPERATION 1/24/86 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED bilateral iliofemoral stenosis | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/23 19 86, to 1/27 19 86, that (I) (we) lost saw the deceased alive on 1/27 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Randy H. Schuster | | | | | DEGREE MD | | 22c. DATE SIGNED 1/27/86 | | 22d. ADDRESS Sinai Hosp. Inc. |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) RHSchuster | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE JAN. 29, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY HAR SINAI BENEVOLENT SOC. ROSEDALE BALTO. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD | |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | 25. DATE REG'D. BY REGISTRAR FEB 05 1986 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in person at the office.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP



CHILLY

BOX 201

008166

Items# 16a G 613 3/21/86 STATE OF MARYLAND

01530

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|--|--|---|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) CHARLES M SCHLINING | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 3, 1986 | | | 2b. HOUR 7:28 P.M. | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 7 19 15 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mold Maker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | | 13b. COUNTY Baltimore | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 2118 Whistler Avenue 21230 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Louis W. Schlining | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Theresa Held | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 212-10-8339 | | 17. INFORMANT ADDRESS Tom Macey, 4550 Solomons Island Road 20639 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myelogenous Leukemia DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Renal failure | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from 1/2 , 19 86 , to 1/3 , 19 86 , that (1) (we) lost saw the deceased alive on 1/3 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE John E. Humphries | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 1/3/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) John E. Humphries | | | | 22e. ADDRESS Johns Hopkins Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-7-86 | | 23c. NAME OF CEMETERY OR CREMATORY Maryland Nat. Mem. Pk. Laurel | | 23d. LOCATION CITY OR TOWN COUNTY STATE P.G. Md. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Hubbard Funeral Home, Inc., 4107 Wilkens Ave. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 6 1986 | | 25b. REGISTRAR'S SIGNATURE <i>John E. Humphries</i> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical professional must be notified by phone.

BP _____

001800

POST COLLECTION BOX

DAVID M. WILKINSON



035123

Item 2a 0612 2/5/ 86

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01531

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Karl H. Schloss | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 29 1986 | | | 2b. HOUR 7:15 am | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 1 10 1932 | | 6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital - Balto. Md. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) disabled, Formula Maker | | 12b. KIND OF BUSINESS OR INDUSTRY King Syrr | |
| 13a. STATE Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 1739 Battery Ave 21230 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Karl M Schloss | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine --- Reiff | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unknown | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Yes, 1952-54 21628-9308 | | 17. INFORMANT ADDRESS chart Dolores L. Schloss, Same as 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis + respiratory failure DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 hours |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) liver failure | | | | | | | | | |
| 19a. DATE OF OPERATION 1/27/86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ischemic (L) leg | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N/A | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) N/A | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/19, 1986, to 1/29, 1986, that (I) (we) lost saw the deceased alive on 1/29, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Matthew Wagner | | | | DEGREE MD | | | | 22c. DATE SIGNED 1/29/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Matthew Wagner | | | | 22e. ADDRESS Mercy Hospital Baltimore MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 2/1/86 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Co. Md. | | | |
| 24. FUNERAL DIRECTOR NAME McCully Funeral Home | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 31 1986 | | | | | |

MEDICAL CERTIFICATION

99

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

001753

2008 OCT 10 2:00P

NOV 11 2008



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01532

028103

| | | | |
|--|--|---|---|
| FOR 1. STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST <u>ELIZABETH</u> LAST <u>SCHLOSSER</u> <u>ELIZABETH SCHLOSSER</u> | | 2a. DATE OF DEATH MONTH <u>1</u> DAY <u>23</u> YEAR <u>86</u> HOUR <u>12:54</u> PM | |
| 3. SEX <u>Female</u> | 4. RACE <u>Caucasian</u> | 5. DATE OF BIRTH MONTH <u>12</u> DAY <u>04</u> YEAR <u>13</u> | 6. AGE (IN YEARS LAST BIRTHDAY) <u>72</u> YRS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u> | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD. |
| 10. CITY OR TOWN OF DEATH <u>Baltimore</u> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Deacon Hospital Medical Center South</u> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u> |
| 12b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Maryland</u> | 13b. COUNTY <u>Baltimore</u> | 13c. CITY OR TOWN <u>Catonsville</u> | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST <u>Edward</u> MIDDLE LAST <u>Carter</u> | | 15. MOTHER'S MAIDEN NAME FIRST <u>Leona</u> MIDDLE LAST <u>Russell</u> | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u> | | 17. INFORMANT ADDRESS <u>Robert W. Schlosser Same as # 13</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>- Cordiorespiratory Arrest -</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>- Generalized Arteriosclerosis -</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u> | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/6</u> 19 <u>86</u> to <u>1/33</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>1/6</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE <u>[Signature]</u> | DEGREE <u></u> | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED <u>1-23-86</u> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>RUBEN REIDER M.D.</u> | 22e. ADDRESS <u>7445A FURNACE BRANCH Rd Glen</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Entombment</u> | 23b. DATE <u>1/25/86</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Mausoleum</u> | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore Maryland</u> |
| 24. FUNERAL DIRECTOR <u>Leroy M. & Russell C. Witzke Funeral Homes P.A.</u> <u>1630 Edmondson Avenue, Catonsville, MD. 21228</u> | | 25a. DATE REC'D. BY REGISTRAR <u>JAN 24 1986</u> | |
| | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

001850

20% COTTON 1874

WINTER 1874

029011

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) Brooxie V. Schneider | | | 2a. DATE OF DEATH MONTH DAY YEAR 1/23/86 11/07/84 | | 2b. HOUR 3:40 P.M. |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 11 9 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANCIS SCOTT KEY MC. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Matron | | 12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Dundalk | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Montana Burnett | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louisa Atkins | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 401-12-4663 | | 17. INFORMANT ADDRESS Ruth Vicars Same as 13e | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>PROBABLE SEPSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>UNRESECTABLE ADENOCARCINOMA OF CAECUM</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u> <u>1 week</u> <u>< 3 weeks</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NO</u> | | | | | |
| 19a. DATE OF OPERATION <u>12/26/85</u> | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>TUMOR IN THE PORTAL VEIN</u> | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <u>---</u> | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>---</u> | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>---</u> | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/5/86</u> to <u>1/23/86</u> , that (I) (we) last saw the deceased alive on <u>1/23/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>R. Schettino</u> | | DEGREE <u>MD</u> | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <u>1/23/86</u> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>SCHETTINO, RAYMOND</u> | | 22e. ADDRESS <u>FRANCIS SCOTT KEY MC</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 1/27/1986 | 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | |
| 24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. | | ADDRESS 7922 Wise Avenue Dundalk, Maryland 21222 | | 25a. DATE REC'D. BY REGISTRAR JAN 21 1986 | 25b. REGISTRAR'S SIGNATURE <u>William J. Jones</u> |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

FRANK, SCOTT KEY MC

01534

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1- STATE
REGISTRAR

REG. NO.

0270183

| | | | | |
|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) HATTIE E. SCHOENBERGER | | 2a. DATE OF DEATH MONTH DAY YEAR 1-20-86 | | 2b. HOUR M |
| 3. SEX F | 4. RACE W | 5. DATE OF BIRTH MONTH DAY YEAR 10-24-1912 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY - MD. |
| 10. CITY OR TOWN OF DEATH BALTO. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2418 E. MADISON ST. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER | 12b. KIND OF BUSINESS OR INDUSTRY HOME |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | |
| 13a. STATE MD. | 13b. COUNTY | 13c. CITY OR TOWN BALTO. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 2418 E. MADISON ST. 21205 |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOHN GUILTA | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BARBETTA DIETZ | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 213-03-5409 | | 17. INFORMANT ADDRESS Mrs. Clara M. Saunders - 801 N. Patterson Ave. 21205 |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction. DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardio Vasc. Disease DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1a

MEDICAL CERTIFICATION

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| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov 15 - 1985 , to Jan 20 - 1986 , that (I) (we) lost saw the deceased alive on Nov 15 - 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE A. Letu'scaro | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. Letu'scaro | | 22e. ADDRESS Charles Hays, M.D. Practice Office | |

| | | | |
|--|-----------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE 1-24-86 | 23c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER CEM. | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO., MD. |
| 24. FUNERAL DIRECTOR NAME ADDRESS John G. Giller - 2334 Jefferson St. | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 23 1986 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified to check.

037010

HATTIE E. JOHNSON

1-20-80

10-11-1914

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|---|--|--|---|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) CLARENCE C. SCHOTT | | | 2a. DATE OF DEATH MONTH DAY YEAR January 14, 1986 | | | 2b. HOUR 5:30 P.M. | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Jan, 3, 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1209 Havenwood Road | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager | | 12b. KIND OF BUSINESS OR INDUSTRY Plant | |
| 13a. STATE MD | | 13b. COUNTY | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Schott | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Geltz | | 13e. STREET ADDRESS / ZIP CODE 1209 Havenwood Rd., 21218 | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 400 07 3261 | | 17. INFORMANT 271 E. Central Ave. John C. Schott, Paoli, PA 19301 | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardio-vasc. Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CA Prostate & metastasis to Bone, Renal, etc.</u> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>MLU</u> <u>YRS</u> <u>YRS</u> | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>2-2</u> 19 <u>72</u> to <u>1-14</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>12-29</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE <u>Dr. S. J. Venable, Jr.</u> MD | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1-14-86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. S. J. Venable, Jr., MD | | | | 22e. ADDRESS 7215 York Road, Balto., MD 21212 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/17/86 | | 23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. County, MD | | |
| 24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212 | | | | 25a. DATE REC'D. BY REGISTRAR JAN 17 1986 | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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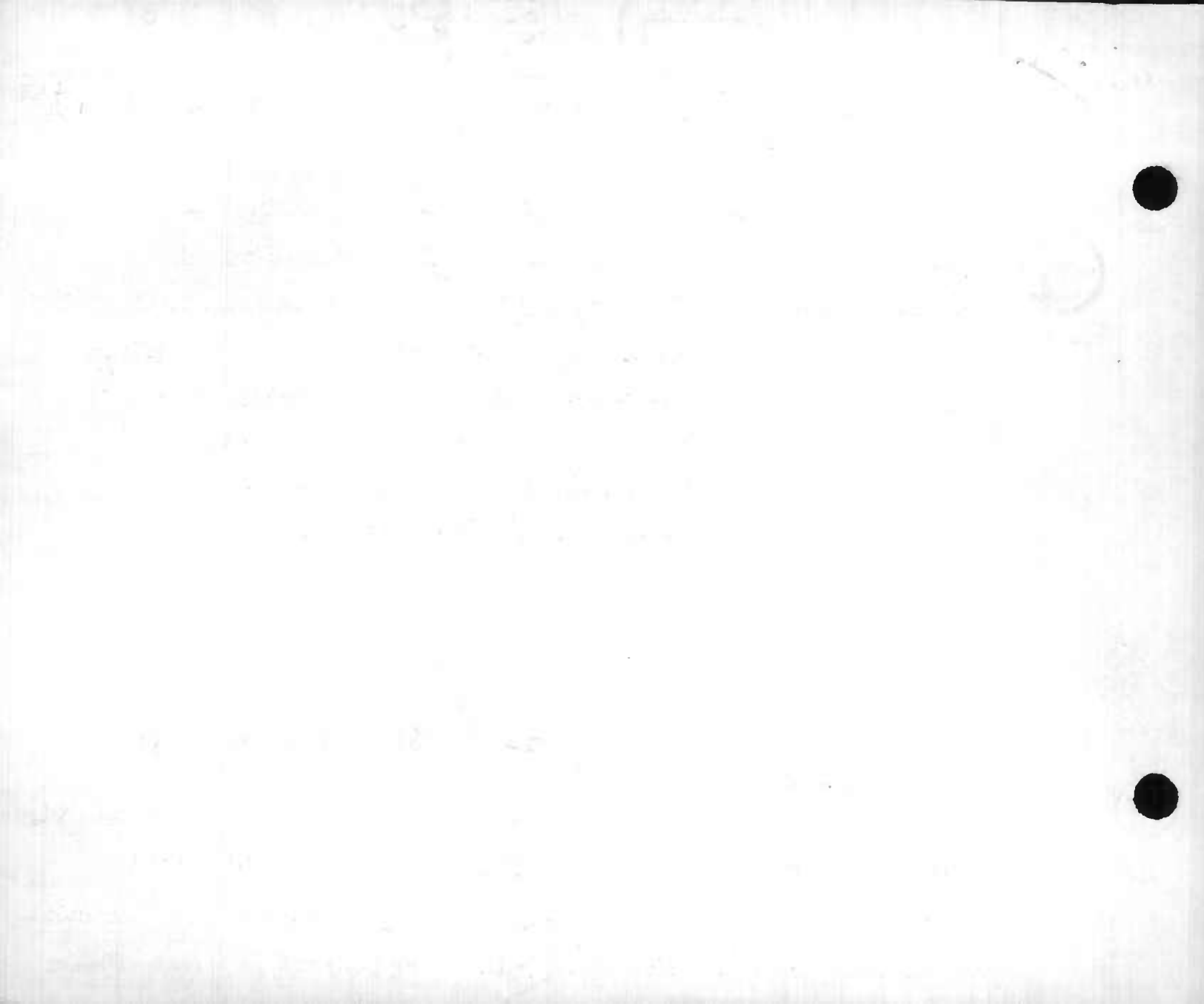
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01536

037013

| | | | |
|---|--|---|--|
| FOR 1 - STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) Annette | | 2a. DATE OF DEATH MONTH DAY YEAR 1-30-86 | |
| 2. SEX Female | | 2b. HOUR 1:45 AM | |
| 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 27, 1898 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | 6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS. | |
| 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | |
| 13c. CITY OR TOWN Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE 708 Bonifant Street 20910 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Peter Germaine | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine McMahon | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 063-20-2291 | |
| 17. INFORMANT Loretta Santmyer | | ADDRESS Daughter Same as 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Alzheimer's disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Recurrent Pneumonia PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | |
| MEDICAL CERTIFICATION | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-29-86 to 1-30-86, that (I) (we) last saw the deceased alive on 1-30-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE H. Devadoss MD | | 22c. DATE SIGNED 1-30-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. DEVADOSS | | 22e. ADDRESS Provident Hospital | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 01/30/86 | |
| 23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia | |
| 24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr. 500 University Blvd., W. Silver Spring, Md. | | 25a. DATE REC'D. BY REGISTRAR FEB 04 1986 | |
| 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



022029

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01537

FOR
1. STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|---|--|--|---|---|--|---|--|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) BESSIE M. SCHREIBER | | | 2a. DATE OF DEATH MONTH 01 DAY 16 YEAR 86 | | | 2b. HOUR 2015 M | | | | | |
| 3. SEX Female | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH 06 DAY 02 YEAR 10 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY OF MARYLAND CANCER CENTER | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | | 12b. KIND OF BUSINESS OR INDUSTRY Ret. Seamstress | | |
| 13a. STATE MD | | | | 13b. CITY OR TOWN BALTIMORE | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE Balto. Md. 600 UHST ST. 21230 | | | |
| 14. FATHER'S NAME FIRST WILLIAM MIDDLE --- LAST BRADLEY | | | | 15. MOTHER'S MAIDEN NAME FIRST BEJIE MIDDLE --- LAST CARRETT | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 217-03-889 | | 17. INFORMANT E. Shirley Taylor D. K. TAYLOR C/- V.M.C.-C | | | | | |

| | | | |
|---|--|--|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINS | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARDIAC FAILURE | | DAYS | |
| (c) MYOCARDIAL INFARCT | | DAYS | |

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 METASTATIC CA BREAST | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 01-09-1986 to 01-16-1986 that (I) (we) last saw the deceased alive on 01-16-1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Kerry Taylor MD | | | | DEGREE | | 22c. DATE SIGNED 1-16-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) KERRY TAYLOR | | | | 22e. ADDRESS C/- V.M.C.-C | | | |

| | | | | | | | |
|---|--|-----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/20/86 | | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem.Pk. | | 23d. LOCATION Elkridge Howard Co. Md. | |
| 24. FUNERAL DIRECTOR Balto. Md. 21230 McCauley Funeral Home, 130 E. Fort Ave. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 20 1986 | | 25b. REGISTRAR'S SIGNATURE John Davidson-Randall | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page and return it to the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

BP

022006

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01538

REG. NO.

| | | | | | |
|---|--|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) CARL L. SCHREINER | | | 2a. DATE OF DEATH MONTH DAY YEAR 1-18-86 | | 2b. HOUR 432 A.M. |
| 3. SEX MALE | 4. RACE CAUCASIAN | 5. DATE OF BIRTH MONTH DAY YEAR 2-05-40 | | 6. AGE (IN YEARS LAST BIRTHDAY) 45 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GENERAL HOSP | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ENGINEER | 12b. KIND OF BUSINESS OR INDUSTRY B.G. & E | |
| 13a. STATE MD. | | 13b. COUNTY BALT. | 13c. CITY OR TOWN BALT. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 3207 Hamilton Ave. 21214 |
| 14. FATHER'S NAME FIRST MIDDLE LAST GEORGE SCHREINER | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA MILLER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO 218-36-8363 | | 17. INFORMANT ADDRESS Mrs. Dorothy M. Parsley - 3207 Hamilton Ave. 21214 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF: (b) Metastatic bladder cancer DUE TO, OR AS A CONSEQUENCE OF: (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/10/86 to 1/18/86 , that (I) (we) last saw the deceased alive on 1/10/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Michael E. Collier, M.D. | | DEGREE M.D. | | 22c. DATE SIGNED 1/18/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL E. COLLIER, M.D. | | 22e. ADDRESS 3001 S. HANOVER ST. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 1-22-86 | 23c. NAME OF CEMETERY OR CREMATORY LORRAINE PARK Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD |
| 24. FUNERAL DIRECTOR Harry Miller - 7527 Harford Rd. | | | 25a. DATE REC'D. BY REGISTRAR JAN 20 1986 | | |
| | | | 25b. REGISTRAR'S SIGNATURE Davidson-Pendall | | |

MEDICAL CERTIFICATION

29

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(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificates. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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017096

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) JOSEPHINE A. SCHUELER | | | 2a. DATE OF DEATH MONTH DAY YEAR 01 13 86 | | | 2b. HOUR 6:55 AM | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR July 27, 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOOD SAMARITAN HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 13a. STATE Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 21239 6401 Loch Raven Blvd. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Vincent Szvicka | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Magdalen Adomaiciute | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | |
| 16b. SOCIAL SECURITY NO. 217 329813 | | | 17. INFORMANT ADDRESS 21206 Roger A. Schueler, 5700 Kenwood Ave. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>transient infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>atherosclerosis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 min. 1 wk. decades | | | | | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>none</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (a) (this hospital) attended the deceased from <u>1/4/86</u> to <u>1/13/86</u> , that (a) (we) last saw the deceased alive on <u>11/13/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Dan McDougall | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/13/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAN MCDUGALL | | | 22e. ADDRESS GOOD SAMARITAN HOSP. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE Jan. 16, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | | |
| 24. FUNERAL DIRECTOR ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Balto., Md. 21214 | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 14 1986 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|---|--|---|--|--|---------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) HENRY — SCHWARTZ | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 4 86 | | 2b. HOUR 9:45 M | |
| 3. SEX MALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH SEPT. 19, 1912 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS | | 7. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE MD | | 9. BALTIMORE CITY OR COUNTY OF DEATH CITY OF BALTO MD | | 12b. KIND OF BUSINESS OR INDUSTRY SEAMAN | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHN L. DEATON HOSPITAL MED CTR | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MERCHANT MARINE | | |
| 13a. STATE MD | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ABRAHAM N. SCHWARTZ | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MIRIAM GOLDA PREIL | | 16. SOCIAL SECURITY NO. 085-07-0328 | | |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 17. INFORMANT ADDRESS MRS. RHODA SCHWARTZ 2956 FREEWAY (21227) | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF, (b) Metastatic gastric adenocarcinoma. DUE TO, OR AS A CONSEQUENCE OF (c) old CIA. | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | |
| 19a. DATE OF OPERATION 12/18 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED old CIA. | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/18 , 19 86 , to 1/4 , 19 86 , that (I) (we) lost saw the deceased alive on 1/4 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE Gail Reedman MD | | DEGREE MD | | 22c. DATE SIGNED 1/4/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) GAIL REEDMAN MD | | 22e. ADDRESS UNIV OF MARYLAND, DEPT FAMILY PRACTICE. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 1/5/86 | | 23c. NAME OF CEMETERY OR CREMATORY SHAAREI ZION CEM | | |
| 23d. LOCATION COUNTY STATE ROSEDALE BALTO MD | | 24. FUNERAL DIRECTOR NAME ADDRESS SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO, MD 21215 | | | | |
| 25. DATE REC'D. BY REGISTRAR JAN 8 1986 | | 26. REGISTRAR'S SIGNATURE John Deaton-Rose | | | | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove chapter 21 and 22 and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified and advised.

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REPORT NOT FOR RELEASE

CONFIDENTIAL



0280418

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

01541

| | | | | | | | | | |
|--|--|---|---|--|---|--|---|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) PAUL | | | 2a DATE OF DEATH MONTH DAY YEAR JANUARY 19, 1986 | | | 2b HOUR 9:46 AM | | | |
| 3 SEX MALE | | 4 RACE WHITE | | 5 DATE OF BIRTH MONTH DAY YEAR JAN. 20, 1911 | | 6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS. | | 7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10 CITY OR TOWN OF DEATH BALTIMORE | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PROPRIETOR | | 12b KIND OF BUSINESS OR INDUSTRY ADMIRAL FURN. | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND | | 13b CITY OR TOWN BALTIMORE | | 13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d STREET ADDRESS / ZIP CODE 8410 CARLSON LANE (21207) | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST MYER SCHWARTZ | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GOLDA COHEN | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b SOCIAL SECURITY NO. 214-20-3431 | | 17 INFORMANT ADDRESS MRS. ROSE SCHWARTZ 8410 CARLSON LANE (21207) | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) acute myocardial infarction | | | | | | | | 2 hours | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (1) (this hospital) attended the deceased from 19 84 to 19 86 , that (1) (we) last saw the deceased alive on 1-18 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE B. R. Mosher | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED 1/20/86 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) BERNARD SCHOCHET | | | | | | 22e ADDRESS 6804 PARK HEIGHTS AVE. (21215) | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b DATE 1-21-86 | | 23c NAME OF CEMETERY OR CREMATORY RIGA KURLANDER VEREIN | | 23d LOCATION CITY OR TOWN COUNTY STATE ROSEDALE, BALTO., MD. | | |
| 24 FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. | | | | | | 25a DATE REC'D BY REGISTRAR JAN 24 1986 | | 25b REGISTRAR'S SIGNATURE [Signature] | |
| 26 HOME ADDRESS 6014 REISTERSTOWN RD. BALTO., MD. (21215) | | | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL, OR ATTENDING PHYSICIAN: This certificate requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked for item 18, was any injury or other traumatic event, the medical examiner should be notified.

BP

LIBRARY OF CONGRESS

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FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

01E0237863

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|---|--|--|--|---|----------------------------|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Harry A Schwinabart | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 2 86 | | 2b. HOUR 10:27AM | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 2 7 13 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) auto service station | | 12b. KIND OF BUSINESS OR INDUSTRY Retired | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Catonsville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 215 Newburg Avenue 21228 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James W. Schwinabart | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hester A. Stuckey | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II | | 17. INFORMANT Ida Schwinabart | | ADDRESS Same as # 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Ectopic Tachycardia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Old Infarct</u> Anteroseptal Myo. Infarct 10 yrs DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Atherosclerosis</u> 25 yrs | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u> | | | | | | | | | |
| 19a. DATE OF OPERATION 0 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-7 to 1-2 19 86 , that (I) (we) lost saw the deceased alive on 1-2 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Kyle G. Swisher Jr MD. | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 1-2 86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kyle G. Swisher Jr MD | | | | 22e. ADDRESS 3455 Wilkerson Ave - Balto, MD 21229 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/5/86 | | 23c. NAME OF CEMETERY OR CREMATORY Poplar Springs Meth. Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Poplar Springs MD. | | | |
| 24. FUNERAL DIRECTOR NAME Leroy M. & Russell C. Witzke Funeral Homes P.A. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 6 1986 | | 25b. REGISTRAR'S SIGNATURE Jane Davidson-Randall | | | |
| ADDRESS 1630 Edmondson Avenue, Catonsville, MD. 21228 | | | | | | | | | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called on or before the body is released for burial or cremation.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the body after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

RECEIVED OCT 10 1960

WILLIAM



017126

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-1. RETAIN IN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|------------------|---|--|---|-------------------------------|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JAMES E. SCOTT, SR. | | | | | | | | | | 2b. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1-11-86 ¹⁹ | |
| 3. SEX male | 4. RACE black | 5. DATE OF BIRTH MONTH DAY YEAR 10 13 1941 | 6. AGE (IN YEARS LAST BIRTHDAY) 44 YRS. | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN | 2c. DATE PRONOUNCED DEAD 1-11-86 ¹⁹ | | 2d. HOUR 10:35 ^{PM} | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md | | 7b. CITIZEN OF WHAT COUNTRY? U S A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY Longshoreman | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Md | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 826 Wildwood Parkway 21229 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John A. Johnson | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Scott | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 216-40-3595 | | 17. INFORMANT ADDRESS Mary Scott Rt 1 Box 61 East New Market Md 21631 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Margarita A. Korell, M.D. | | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 1-12-86 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/19/86 | | 23c. NAME OF CEMETERY OR CREMATORY Thompson Chapel Cem | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Thompson town Md | | | |
| 24. FUNERAL DIRECTOR NAME William C. March F/H West 4300 Wabash Avenue | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 14 1986 | | 25b. REGISTRAR'S SIGNATURE | | | |

20% COTTON FIBER

WELLS FLOW



020023

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|--|---|---|-----------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Robert F. Sehorn | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 13 86 | | 2b. HOUR 10:30 AM | | |
| 3. SEX MALE | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR 02 19 62 | | 6. AGE (IN YEARS LAST BIRTHDAY) 23 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Puerto Rico | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Maryland Shock Trauma | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mech. | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Herbert I. Sehorn | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara Workman | | 13e. STREET ADDRESS / ZIP CODE 5617 Pilegram Rd. Balt. Md. 21214 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 216-82-0674 | | 17. INFORMANT ADDRESS Herbert I. Sehorn, Same as 13e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Total Bilateral Cortex Infarction and Brainstem Death DUE TO, OR AS A CONSEQUENCE OF (b) Brain Trauma DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 8121 | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1:36 AM 1-11-86 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) passenger of auto/auto collision | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) street | | 21f. LOCATION CITY OR TOWN COUNTY STATE Perring Pkwy. & Oakleigh Rd. Balto., Maryland | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE John R. Stene, MD. | | DEGREE MD. CERTIFICATION APPROVED BY MEDICAL EXAMINER ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 1/13/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) John R. Stene MD | | 22e. ADDRESS M.I.E.M.S.S. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 1-16-86 | | 23c. NAME OF CEMETERY OR CREMATORY Westview | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md. | |
| 24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc., 5305 Harford Rd. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 16 1986 | | 25b. REGISTRAR'S SIGNATURE John Davidson | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Harriet L. Johnson, 176

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15. *What is the main point of the passage?*

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD., 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M
 BP
DHMH - 17
(VR A15 ME (1))

 1- FOR
STATE
REGISTRAR

 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|---------|--|-------------------|---|---|---|---|-----------------------------------|-----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE KNOWN OF DEATH | | <input checked="" type="checkbox"/> MONTH | DAY | YEAR | 2b. HOUR |
| Dorothy Seicke | | | | | 1/ 25/19 86 | | | | | M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | 7d. HOUR | |
| Female | White | 8 8 08 | | 77 YRS. | | | 1/ 25/19 86 | | 10:52 P M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| MD | | USA | | Baltimore City, | | | | | MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | | St. Agnes Hospital | | | | Housewife | | Home | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| MD | | Baltimore | Arbutus | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 4720 Aldgate Green 21227 | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| Noan Byers | | | | Bertha Ruff | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | |
| No | | | | Thomas J. Seicke Same as 13 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 1a. | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) M.D. Assistant | | | | DATE SIGNED 1/26/86 | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | |
| Gregory R. Kauffman, M.D. | | 111 Penn St. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | |
| Burial | | 1-28-86 | | Good Shepard Cemetery | | Howard County, MD | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| MacNabb Funeral Home, Catonsville, MD | | | | JAN 28 1986 | | [Signature] | | | | |

BOOK

RECEIVED

WINSTON-SALEM



1901

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

017114

| | | | | | |
|---|---|---|---|--|--------------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) HARRIE MAURICE SELZNICK | | | 2a. DATE OF DEATH MONTH DAY YEAR 1-11-1986 | | 2b. HOUR 345A^{AM} |
| 3. SEX MALE | 4. RACE CAUCASIAN | 5. DATE OF BIRTH MONTH DAY YEAR 10-27-1911 | 6. AGE [IN YEARS (LAST BIRTHDAY)] 74 YRS | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WISCONSIN | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LEVINDALE HEBREW HOME | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ADMINISTRATOR | 12b. KIND OF BUSINESS OR INDUSTRY EDUCATION | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY BALTIMORE 13c. CITY OR TOWN BALTIMORE | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 6807 PARK HTS. AVE. 21215 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST LOUIS J. SELZNICK | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE IDA PROMMER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. (IF NOT KNOWN, GIVE WAR OR NAVY) WWII-NAVY 388-05-0370 | 17. INFORMANT MRS. MIRIAM SELZNICK APT. 3-I 6807 PARK HTS. AVE. BALTO., MD 21215 | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

METASTATIC COLONIC CA

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

MEDICAL CERTIFICATION

| | | | |
|---|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (this hospital) attended the deceased from 1/11 19 86 to 1/11 19 86 , that (we) last saw the deceased alive on 1/11 19 86 , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death. | | | |
| 22b. SIGNATURE <i>Estrelita O. Kru</i> | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/11/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ESTRELITA O. KRU | | 22e. ADDRESS LEVINDALE HEBREW GERIATRIC CENTER Hospital | |

| | | | |
|---|-----------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE JAN. 13, 1986 | 23c. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW | 23d. LOCATION CITY OR TOWN COUNTY STATE REISTERSTOWN BALTO. MD |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215 | | 25a. DATE REC'D. BY REGISTRAR JAN 14 1986 25b. REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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BALTIMORE



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) LILLIAN SEREDICZ | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 7, 1986 | | 2b. HOUR MIN. 6:48A | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR 5-9-1900 | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 85 yrs. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | 8. IF UNDER 24 HRS HOURS MIN. | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 9b. CITIZEN OF WHAT COUNTRY? USA | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital Corp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Press Operator | |
| 12b. KIND OF BUSINESS OR INDUSTRY Can Corp. | | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | 13b. COUNTY Baltimore | |
| 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 2702 Hudson Street 21224 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Unknown | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-01-7294 | | 17. INFORMANT Sr. ADDRESS 21206 Melvin Seredicz 4432 Parkside Drive | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) SEPSIS DUE TO, OR AS A CONSEQUENCE OF (c) DECUBITI, ORGANIC BRAIN SYNDROME PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| MEDICAL CERTIFICATION | | | | | |
| 19a. DATE OF OPERATION DECEMBER 13, 1985 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED INFECTED DECUBITIS ULCER | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 10, 1985 to JANUARY 7, 1986 , that (I) (we) last saw the deceased alive on JANUARY 7, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Carol S. Ramsey | | DEGREE D.O. | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CAROL S. RAMSEY D.O. | | 22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTO., MD. 21231 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-9-85 | | 23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cem. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md. | | 24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane, Balto., Md. 21213 | | | |
| 25a. DATE REC'D. BY REGISTRAR JAN 7 1986 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified by the funeral director.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | |
|---|---|---|---|--|------------------------------------|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| FIRST MIDDLE LAST ELOUISE GLADYS SERIO | | | MONTH DAY YEAR 1 8 86 | | | 5 P M | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS |
| FEMALE | WHITE | MONTH DAY YEAR 10 10 26 | 59 YRS | | | MONTHS DAYS | | HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| MARYLAND | U.S.A. | | Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | University of Maryland Hospital | | Tavern owner | | | Tavern | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | |
| Maryland | | | Baltimore | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | |
| Albert S. Muhl | | | Elouise McKenzie | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | |
| NO | | | 212-22-1082 | | | 21230 Vincent T. Serio, Sr. 2300 Sidney Ave. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic melanoma</u> | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0 | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| 10/31/85 | | | Intercranial Hematoma | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that the deceased attended the deceased from _____, 19 85, to Jan 8, 19 86, that (we) lost saw the deceased alive on Jan 8, 19 86, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death. | | | 22b. SIGNATURE Robert W. Nudelman MD | | | 22c. DATE SIGNED 1/8/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | |
| NUDELMAN | | | 22 S. Greene St Baltimore MD 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | | 1/11/86 | | Meadowridge Mem. Pk. | | Elkridge Howard County Md | |
| 24. FUNERAL DIRECTOR NAME | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRATION NUMBER | | |
| Hubbard Funeral Home, Inc. | | | 21229 4107 Wilkens Ave. | | | JAN 10 1986 | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate from the file and place it in the file of the deceased. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove the certificate from the file and place it in the file of the deceased. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

IMPORTANT: Item 21 is marked or item 18 shows any injury, or other traumatic condition, medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, pages 1 and 2 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

| | | | | | | | | | | |
|--|--|---|--|---|--|--|-----------------------------|--|---|--|
| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MABEL BERTHA SEVICK | | | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 28, 1986 | | | 2b. HOUR 1:10 P.M. | | |
| 3. SEX Female | | 4. RACE Cauc. | | 5. DATE OF BIRTH MONTH DAY YEAR 8/30/05 | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hosp. Corp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY - | | |
| 13a. STATE Md. | | | | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME Adolf Helmbold | | | | | 15. MOTHER'S MAIDEN NAME Augusta Unknown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) - | | 17. INFORMANT ADDRESS 5 Frank J. Sevick, 3029 Harrow Rd., Spring Hill, Florida 33526 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) GESTINE PERFURATIUN PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | |
| 19a. DATE OF OPERATION JANUARY 26, 1986 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED PERFURATED PEPTIC ULCER | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JANUARY 25, 19 86, to JANUARY 28, 19 86, that (I) (we) last saw the deceased alive on JANUARY 28, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE M. B. B. B. | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MURARI LAL BIJPURIA M.D. | | | | 22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 NORTH BROADWAY BALTO., MD. 21231 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/31/86 | | 23c. NAME OF CEMETERY OR CREMATORY Balto. National | | 23d. LOCATION Balto., Md. COUNTY STATE | | | | |
| 24. FUNERAL HOME Schimonek Funeral Home, Inc. 3331 Brehms Lane, Balto., Md. 21213 | | | | 25a. DATE REC'D. BY REGISTRAR JAN 31 1986 | | 25b. REGISTRAR'S SIGNATURE John Davidson-Randall | | | | |

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

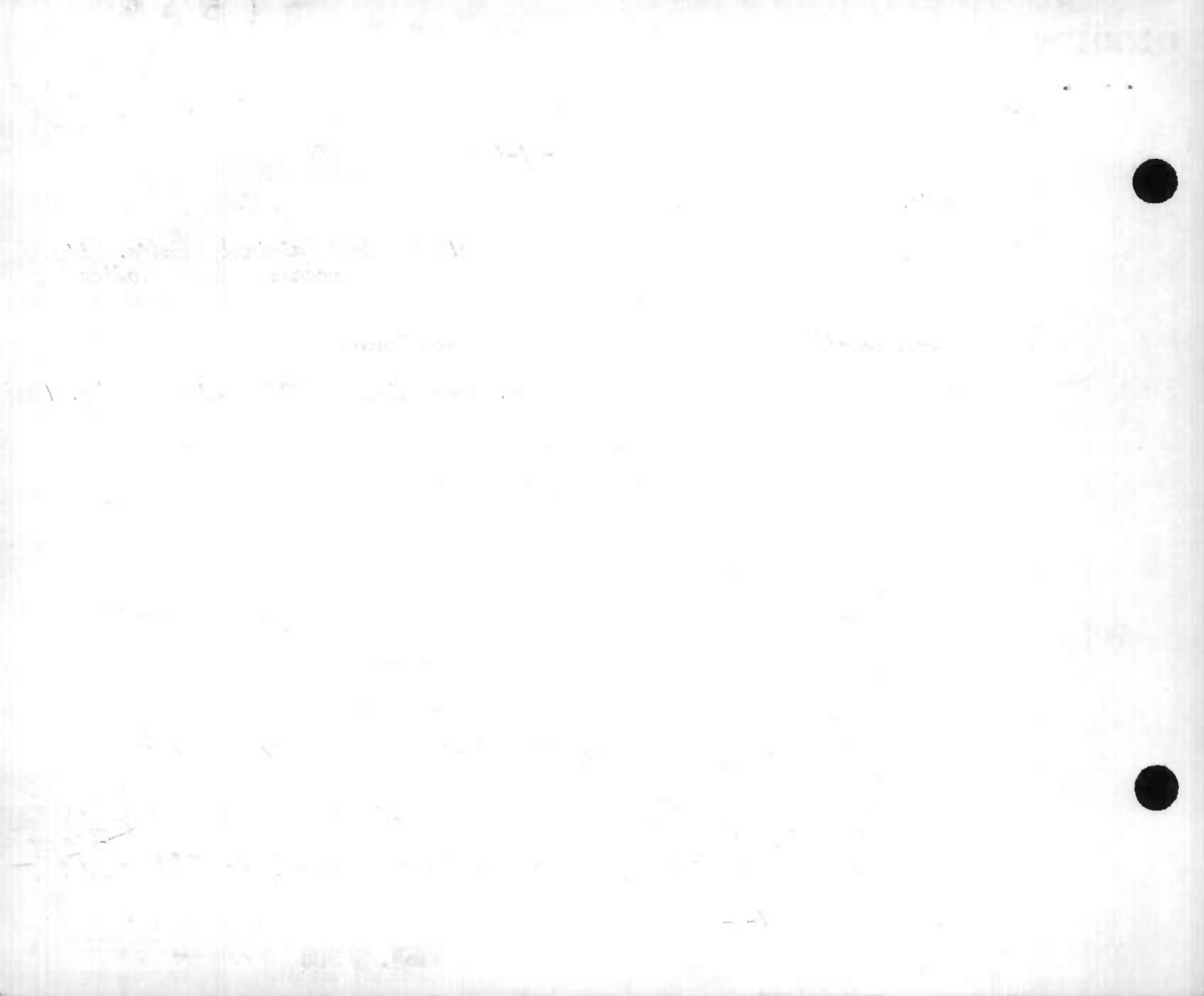
| | | | | | |
|--|--|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mildred N. Sewell | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 6 86 | | 2b. HOUR 7 M |
| 3. SEX Fem. | 4. RACE Cau. | 5. DATE OF BIRTH MONTH DAY YEAR 3-21-1920 | | 6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD. | |
| 10. CITY OR TOWN OF DEATH Balto. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5947 Benton Heights Ave. 21206 | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk (Criminal Records) | | 12b. KIND OF BUSINESS OR INDUSTRY Police |
| 13a. STATE Md. | | | 13b. COUNTY - | 13c. CITY OR TOWN Balto. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Sewell | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Thomas | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Mary Bridgeman | |
| 16c. ADDRESS 3707 Springwood Ave. 21206 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular DUE TO, OR AS A CONSEQUENCE OF Disease (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____ | | | | | |
| MEDICAL CERTIFICATION | | | | | |
| 19a. DATE OF OPERATION _____ | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/28 to 1/6 , 19 86 , that (I) (we) lost saw the deceased alive on 3/28 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Don Azon, M.D. | | DEGREE M.D. | | 22c. DATE SIGNED 1/6/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DON AZON, M.D. | | 22e. ADDRESS 3009 EVERGREEN AVE BALTO MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-8-86 | | 23c. NAME OF CEMETERY OR CREMATORY Moreland Cem. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Balto. Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME John C. Miller Inc. | | ADDRESS 6415 Belair Rd. 21206 | | 25. DATE REC'D. BY REGISTRAR 9 1986 | |
| 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



020050

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

01351

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--------------|--|--|--|-----------|--|---|--|--|--|---|--|----------------------------------|--|---|--|--------------------------------|--|--|--|----------|--|--|--|-------------------|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST LEE | | MIDDLE SHANDS | | LAST | | 2a. DATE KNOWN OF DEATH ESTI- MATED | | MONTH 1-12-86 | | DAY 9 | | YEAR | | 2b. HOUR 12:20 | | | | | | | | | | | | | | | |
| 3. SEX M | | 4. RACE B | | 5. DATE OF BIRTH MONTH 8 | | DAY 10 | | YEAR 18 | | 6. AGE (IN YEARS) (LAST BIRTHDAY) 67 | | YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7c. DATE PRONOUNCED DEAD | | MONTH 1-12-86 | | DAY 9 | | YEAR | | 2d. HOUR 12:20 | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2674 Pennsylvania Avenue | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | |
| 13a. STATE MARYLAND | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN BALTIMORE | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS 230 N. AMITY STREET | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST NOAH | | | | | | | | MIDDLE SHANDS | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MINNIE | | | | | | | | MIDDLE GREEN | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | | | | | | (IF YES, GIVE WAR OR DATES) | | | | | | | | 16b. SOCIAL SECURITY NO. UNKNOWN | | | | | | | | 17. INFORMANT ADDRESS MARY HEADSPETH 234 N. AMITY STREET | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? (HEAD ONLY) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | | | | | |
| 20d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | | | 20e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 20f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Margarita A. Korell | | | | | | | | TITLE (SPECIFY) M.D. Assistant | | | | | | | | MEDICAL EXAMINER | | | | DATE SIGNED 1-12-86 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | | | | | | | ADDRESS 111 Penn Street | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | | | | | 23b. DATE 1-17-86 | | | | 23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL | | | | 23d. LOCATION CITY OR TOWN ANNE ARUNDEL COUNTY MARYLAND | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H INC. | | | | | | | | | | | | | | | | ADDRESS 1101 E. NORTH AVE. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 16 1986 | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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25M

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DHMH - 17
(VR A15 ME (5))

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10100-200



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | |
|---|--|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) Dorothy E. Shapiro | | | 2a. DATE OF DEATH MONTH 1 DAY 20 YEAR 86 | | 2b. HOUR 1:30pm |
| 3. SEX FEMALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH 2 DAY 25 YEAR 19 | | 6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS | IF UNDER 1 YEAR MONTHS DAYS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) S. BALTO. GEN. HOSP. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | 12b. KIND OF BUSINESS OR INDUSTRY AT HOME | |
| 13a. STATE MARYLAND | | | 13b. COUNTY | 13c. CITY OR TOWN BALTIMORE | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST GORDON MIDDLE LAST MATHIAS | | | 15. MOTHER'S MAIDEN NAME FIRST STELLA MIDDLE LAST JACKSON | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-03-1841 | 17. INFORMANT DANIEL SHAPIRO 3501 HORTON AVE. BALTO., MD 21225 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Acute Hemorrhagic Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic Oat Cell Carcinoma of Lung | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (a) (this hospital) attended the deceased from 12/27 , 19 85 , to 1/20 , 19 86 , that (I) (we) last saw the deceased alive on 1/20 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Gayle P. Myers, M.D. | | | | 22c. DATE SIGNED 1/20/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gayle P. Myers, M.D. | | | | 22e. ADDRESS 3001 S. Hanover St. Baltimore, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE JAN. 22, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY BNAI ISRAEL | |
| 23d. LOCATION BALTIMORE | | COUNTY MARYLAND | | | |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | 25a. DATE REC'D. BY REGISTRAR JAN 24 1986 | |
| 25b. REGISTRAR'S SIGNATURE | | | | | |

MEDICAL CERTIFICATION

29

FOR COLLECT 4400

DND

MINISTER



STOP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | | | | | | | |
|--|--|---|--|---|---------------------------------------|--|---|--|--|--------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) <i>Esther J Shapiro</i> | | | 2a. DATE OF DEATH MONTH <i>1</i> DAY <i>15</i> YEAR <i>86</i> | | | 2b. HOUR <i>9:25 A.M.</i> | | | | | |
| 3. SEX <i>F</i> FEMALE | | 4. RACE <i>W</i> WHITE | | 5. DATE OF BIRTH MONTH <i>12</i> DAY <i>19</i> YEAR <i>1889</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>96</i> YRS | | IF UNDER 1 YEAR MONTHS <i>8</i> DAYS <i>96</i> | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Balto. City</i> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH <i>BALTIMORE</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>LEVINDALE HEBREW HOME</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOUSEWIFE</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i> | | | |
| 13a. STATE <i>MARYLAND</i> | | | 13b. COUNTY <i>BALTIMORE</i> | | 13c. CITY OR TOWN <i>BALTIMORE</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE <i>116 W. UNIV. PKWY. #21210</i> | | |
| 14. FATHER'S NAME FIRST <i>ISAAC</i> MIDDLE <i>FINE</i> LAST <i>FINE</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST <i>DORA</i> MIDDLE <i>UNKNOWN</i> LAST <i>UNKNOWN</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i> | | 16b. SOCIAL SECURITY NO. <i>215-74-4601</i> | | 17. INFORMANT <i>MS. ELAINE R. ROSENBERG</i> | | | | APT. <i>505</i> | | 6210 PARK HTS. AVE. BALTO., MD 21215 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular accident</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>months</i> | | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>no</i> | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <i>1/15</i> to <i>1/15</i> 19 <i>86</i> , that (1) (we) last saw the deceased alive on <i>1/15</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (said) (and) (not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>Levenson</i> MD | | | | 22c. DATE SIGNED <i>1/15/86</i> | | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>S Levenson</i> | | | |
| 22e. ADDRESS <i>LEVINDALE - BALTO., MD 21215</i> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i> | | 23b. DATE <i>JAN. 16, 1986</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>HAR SINAI</i> | | 23d. LOCATION <i>BALTIMORE</i> | | COUNTY <i>MARYLAND</i> | | | |
| 24. FUNERAL DIRECTOR NAME <i>SOL LEVINSON & BROS., INC.</i> ADDRESS <i>6010 REISTERSTOWN RD. BALTO., MD 21215</i> | | | | | | 25a. DATE REC'D. BY REGISTRAR <i>JAN 22 1986</i> | | 25b. REGISTRAR'S SIGNATURE <i>John Davidson</i> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use on the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or filed, 18 shows any injury, or other traumatic event, the medical examiner must be called on once.

BP

201130

037061

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | |
|--|---------|--|--|---|--|--|--|----------------------------|--|--------------------------------|--|-------|--|------|--|-----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| Frances | | Sharp | | | | | | 1/ 30/ 19 86 | | | | | | | | 11:36 P M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | |
| Female | Black | 10/16/ 34 | | 51 YRS. | | | | | | 1/ 30/ 19 86 | | | | | | | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| Md | | USA | | | | Baltimore City, | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH. | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Baltimore | | 1952 Walbrook Ave. | | clerk | | Soc. Sec. | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | | | | | | | |
| Md. | | | | Balto. | | | | 1952 Walbrook Ave. | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| John L. Wallace | | Stevella Parker | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| | | 217-40-6546 | | Dr. Phyllis Wallace | | 1932 Walbrook | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Hypertensive Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) M.D. Assistant | | DATE SIGNED | | 1/31/86 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | | | | | | | | |
| Gregory R. Kauffman, M.D. | | 111 Penn St. | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (IF) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| Burial | | 2-4-86 | | Arbutus Mem | | Balto. Co. Md | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| James A. Maston & Sons | | 1701 Hamens St. | | FEB 04 1986 | | Julia Davidson-Randall | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY OTHER IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETURN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

016026

| | | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--------------------------------|--|-----------------|-----|------------|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR | |
| RAYMOND G. SHEELY | | | | | | | | 1 | | 10 | 86 | 4 43 PM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | | |
| Male | | White | | 7-3-1912 | | 73 YRS. | | MONTHS | | DAYS | | HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | |
| Balto. Md. | | U.S.A. | | | | BALTIMORE CITY MD. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | | | | |
| BALTIMORE | | UNION MEMORIAL HOSPITAL | | | | | | | | | | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | |
| Grounds Keeper | | Sparrows Point | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | Country Club | | | | |
| Md. | | Balto. | | Balto. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 7802 Fairgreen Rd. | | -21224 | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | |
| FIRST | | MIDDLE | | LAST | | FIRST | | MIDDLE | | LAST | | | | |
| Unknown | | Unknown | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | | | | | |
| No | | 213-01-0345 | | Gail P. Diegelman - 5924 Glen Falls Ave. 21206 | | | | | | | | | | |

| | | | |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1: DEATH WAS CAUSED BY: | | | |
| IMMEDIATE CAUSE (a) HEART FAILURE | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | |
| (b) INTRACTABLE ACIDOSIS | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | |
| (c) PREVIOUS MI? | | | |

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

POSSIBLE BACTEREMIA/INFECTION

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| 1-8-86 | | SEVERE CHOLECYSTITIS/?ACIDOSIS | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| NA | | HOUR A.M. MONTH DAY YEAR | | NA | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | |
| WHILE AT WORK <input type="checkbox"/> WHILE AT HOME <input checked="" type="checkbox"/> | | NA | | NA | | CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from 1/8 1986 to 1/10 1986, that (I) (the) last saw the deceased alive on 1/10 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | |
| David V. Nasrallah | | MD | | 1/10/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 22f. REGISTRAR'S SIGNATURE | | | |
| DAVID V. NASRALLAH | | BALTO - MD 21209 | | JAN 13 1986 | | | |

| | | | | | | | |
|---|--|---------------------------------|--|------------------------------------|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Burial | | 1-13-86 | | Meadowridge Cem. | | Elbridge, Md. | |
| 24. FUNERAL DIRECTOR | | 25a. DATE RECEIVED BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| NAME | | ADDRESS | | JAN 13 1986 | | John C. Miller Inc. - 6415 Belair Rd. - 21206 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1820

21-1-1820
x

21-1-1820
x

21-1-1820
x

21-1-1820
x

21-1-1820
x

010015

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|---------|--|------------------------------------|---|----------------------------------|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | HERBERT SHELL | | 2a. DATE KNOWN OF DEATH MONTH DAY YEAR | | 1-6-86 19 | | 2b. HOUR M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS) LAST BIRTHDAY | 7. IF UNDER 1 YR. MONTHS DAYS | 8. IF UNDER 24 HRS. HOURS MIN | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR | | 1-6-86 19 5:36P M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter | | 12b. KIND OF BUSINESS OR INDUSTRY Orn. Irn Wks | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2422 Christian St. 21223 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Henry Shell | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | | | 16b. SOCIAL SECURITY NO. WW II 229-32-6685 | | 17. INFORMANT ADDRESS Dorothy Shell, 2422 Christian St. 21223 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE <i>Margarita A. Korell</i> | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | | | DATE SIGNED 1-7-86 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | Margarita A. Korell, M.D. 111 Penn Street ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | 23e. DATE REC'D. BY REGISTRAR | |
| Burial | | 1-9-86 | | Loudon Park Cemetery | | Baltimore Maryland | | 23f. REGISTRAR'S SIGNATURE | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Hubbard Funeral Home, Inc., | | 4107 Wilkens Ave. | | 21229 | | JAN 8 1986 | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN THE SPACE PROVIDED. PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, DEPARTMENT OF HEALTH AND MENTAL HYGIENE, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

020010



020052

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | |
|--|--|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Rwyter SHEPPARD | | | 2a. DATE OF DEATH MONTH DAY YEAR 1-6-86 | | 2b. HOUR 9 40 P.M. | |
| 3. SEX FEMALE | 4. RACE BLACK | 5. DATE OF BIRTH MONTH DAY YEAR 10-25-17 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALT. CITY MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BCN SECOURS HOSP. | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Custodian | 12b. KIND OF BUSINESS OR INDUSTRY Hospital | |
| 13a. STATE Md. | | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 1922 W. Lexington St. 21223 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOHN SMITH | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY GREEN | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | |
| 16b. SOCIAL SECURITY NO. 220-14-6654 | | 17. INFORMANT ADDRESS Alexander Davis R-1 Box 57 Schulerville S.C. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Emboli DUE TO, OR AS A CONSEQUENCE OF (b) Total Hysterectomy for Ca of endometrium 12/17/85 DUE TO, OR AS A CONSEQUENCE OF (c) Secondary closure of operative wound dehiscence 12/25/85 | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a. | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE CONRADO FERRERO | | DEGREE MD. | | 22c. DATE SIGNED 1-6-86 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CONRADO FERRERO |
| 22e. ADDRESS 5550 Baltimore N.E. Pike 21228 | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-14-86 | | 23c. NAME OF CEMETERY OR CREMATORY Md. Nat. Mem. Park |
| 23d. LOCATION CITY OR TOWN Laurel | | 23e. COUNTY Md. | | 23f. STATE | | 24. FUNERAL DIRECTOR NAME Randolph J. Collick |
| 24a. ADDRESS 243 E. Oliver St. | | 24b. DATE REC'D. BY REGISTRAR JAN 16 1986 | | 24c. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | |

MEDICAL CERTIFICATION

99

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must perform a post-mortem.

BP

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research. The second part of the report is a detailed description of the methods used in the study. This includes a description of the experimental design, the data collection procedures, and the statistical methods used to analyze the data. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous research, and a discussion of the implications of the findings. The final part of the report is a conclusion and a list of references.

2. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research. The second part of the report is a detailed description of the methods used in the study. This includes a description of the experimental design, the data collection procedures, and the statistical methods used to analyze the data. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous research, and a discussion of the implications of the findings. The final part of the report is a conclusion and a list of references.

3. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research. The second part of the report is a detailed description of the methods used in the study. This includes a description of the experimental design, the data collection procedures, and the statistical methods used to analyze the data. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous research, and a discussion of the implications of the findings. The final part of the report is a conclusion and a list of references.

009142

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|--|-------------------|--|--|---|--|------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR |
| Baby Josie Lee Ann Beale Shiflett | | | | | 1/1/86 | | | | 6:10 A.M. |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| female | Caucasian | MONTH DAY YEAR 12 31 85 | | YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | USA | | | Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | St. Agnes Hospital Balto. Md. | | | N/A | | N/A | | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE | | | | |
| N/A | | | Baltimore | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 21230 Ave. Balto. Md. | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| FIRST MIDDLE LAST Joseph Howard Shiflett | | | | FIRST MIDDLE LAST Kimberly Lynn Beale | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| no | | None | | Kimerly Lynn Beale, Same as above | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>respiratory failure</u> | | | | | | | | | 2 hrs. |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| (b) <u>hypaline membrane disease</u> | | | | | | | | | 12 hrs. |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) <u>extreme prematurity</u> | | | | | | | | | 12 hrs. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| | | HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>December 31, 1985</u> to <u>January 1, 1986</u> that (I) (we) last saw the deceased alive on <u>January 1, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | |
| <u>Susan M. Schapiro MD</u> | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 1/1/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | |
| <u>Susan M. Schapiro MD</u> | | | | <u>St. Agnes Hospital</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| Cremation | | 1/5/1986 | | Security Process, Inc. | | CITY OR TOWN COUNTY STATE Catonsville Balto. Co. Md. | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Balto. Md. 21225 McCuilly Funeral Home, 237 E. Patapsco Ave. | | | | JAN 7 1986 | | | | | |

029010

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Walter Shipley | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 1/23/ 19 86 | | | | 2b. HOUR 8:19 P M | |
| 3. SEX male | | 4. RACE black | | 5. DATE OF BIRTH MONTH DAY YEAR 2 2 1939 | | 6. AGE (IN YEARS) (LAST BIRTHDAY) 46 YRS. | | 7c. DATE PRONOUNCED DEAD 1/ 23/ 19 86 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md | | 7b. CITIZEN OF WHAT COUNTRY? U S A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3037 W. Belvedere Ave. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3037 W. Belvedere Avenue 21215 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William E. Shipley | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jeannette Jackson | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 216-36-4444 | | 17. INFORMANT ADDRESS William E. Shipley 3037 W. Belvedere Ave | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Hypertensive Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic Alcoholism | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE Gregory R. Kauffman, M.D. | | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 1/24/86 | |
| EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. | | | | ADDRESS 111 Penn St. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/28/86 | | 23c. NAME OF CEMETERY OR CREMATORY Mt Auburn Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS William C. March F/H West 4300 Wabash Avenue | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE JAN 27 1986 | | | |

FOR COLLECTION

WILSON D. WILSON



007070

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in the funeral director's office. It should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 30M 2/80
(VRA 15, 4)

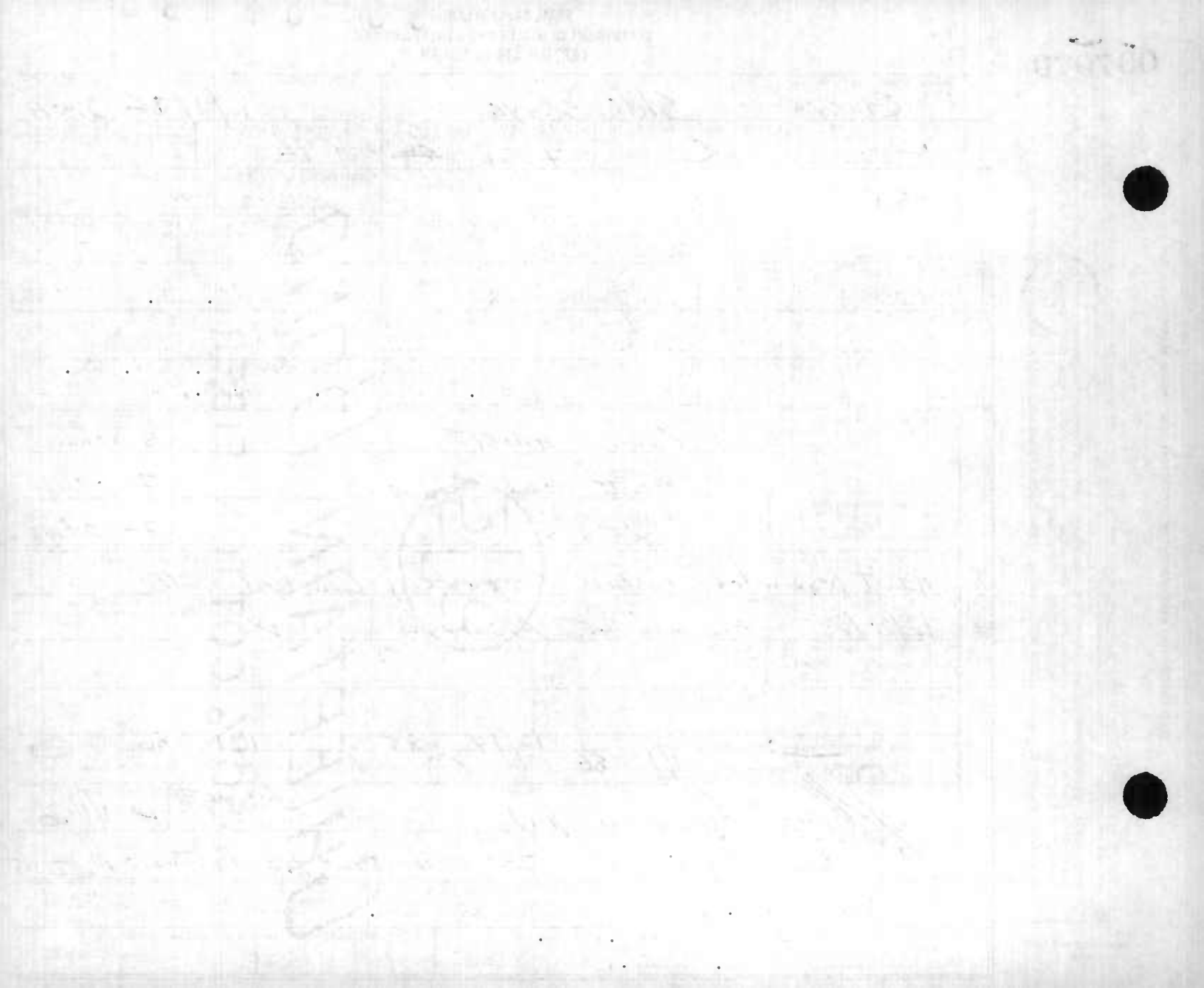
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2b. DATE OF DEATH | | 2b. HOUR | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. STREET ADDRESS | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| 17. INFORMANT | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | |
| 22a. I certify that (I) this hospital attended the deceased from | | 22b. SIGNATURE | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | |
| 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | |
| 25b. REGISTRAR'S SIGNATURE | | 25c. REGISTRAR'S NAME | | 25d. REGISTRAR'S ADDRESS | | 25e. REGISTRAR'S CITY OR TOWN | |

MEDICAL CERTIFICATION

29



009146

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|--|--|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) Doris Virginia SHORTT | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 3 86 | | 2b. HOUR 4:20 PM |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 8 16 22 | | 6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) U.S. Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Maryland | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home maker | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Maryland | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Ford | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lily Harvey | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 2141-20-464 | | 17. INFORMANT ADDRESS Mr. Robert F. Shortt, Sr. Same as above | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular accident. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Urinary tract infection, Pneumonia. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY -YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/27, 1985, to 1/3, 1986, that (I) (we) last saw the deceased alive on 1/3, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Rafael E. Espinosa MD | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/3/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rafael E. Espinosa | | 22e. ADDRESS 3001 South Hanover St. MD, Balto 21230 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/7/1986 | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemt. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. A.A.Co. Maryland |
| 24. FUNERAL DIRECTOR Balto. Md. 21230 McCully Funeral Home, 130 E. Fort Ave. | | 25a. DATE REC'D. BY REGISTRAR JAN 7 1986 | | 25b. REGISTRAR'S SIGNATURE John Davidson-Randall | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



WINTER

2000 COTTON

022045

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

01562

1. FOR
STATE
REGISTRAR

EDGAR SHOWE

REG. NO.

| | | | | | |
|--|---|--|---|---|---|
| 2. DECEASED NAME (TYPE OR PRINT) Edgar S. Showe | | | 2a. DATE OF DEATH MONTH DAY YEAR 1/15/86 | | 2b. HOUR 11/12 M |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 8 21 17 | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE COUNTY MD, USA | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore CITY MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) S. Baltimore General | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Widow | | 12b. KIND OF BUSINESS OR INDUSTRY Construction |
| 13a. STATE MD | | 13b. COUNTY A.A. | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 21225 5700 Brookwood RD |
| 14. FATHER'S NAME FIRST MIDDLE LAST Melvin Showe | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna Mae Davis | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 220-09-7921 | | 17. INFORMANT ADDRESS Mary A. Showe Same as 13e | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CA - WNC, Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Aspiration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>None</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER, INDICATE NATURE OF EXAMINATION) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) sign the death certificate. | | | | | |
| 22b. SIGNATURE <u>[Signature]</u> | | DEGREE | | 22c. DATE SIGNED 1/15/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. A. [Signature] | | 22e. ADDRESS SBCA, BAL, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/17/86 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | |
| 23d. LOCATION CITY OR TOWN Baltimore | | COUNTY A.A. | | STATE Md | |
| 24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hwy Balto Md | | | | 25a. DATE REC'D. BY REGISTRAR JAN 20 1986 | |
| | | | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Department of Health and Mental Hygiene with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "other" (18 shows any injury, or other traumatic event, the medical certificate must be completed by the physician and the funeral director must be notified immediately.)

BP

014154

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | |
|---|---------|--|--|--|--|---|--|---|--|--------------------------------------|--|---|--|----------|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 20. DATE KNOWN OF DEATH | | 21. MONTH | | 22. DAY | | 23. YEAR | | 24. HOUR | |
| THEODORE | | | | | | SHULER | | <input checked="" type="checkbox"/> ESTI- MATED | | 1-7-86 | | 19 | | | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 20. DATE PRONOUNCED DEAD | | 21. MONTH | | 22. DAY | | 23. YEAR | |
| Male | Black | 2 25 59 | | 26 YRS. | | | | | | 1-7-86 | | 19 | | | | 7:45A | |
| 7. BIRTHPLACE | | 15. STATE OR FOREIGN COUNTRY | | 76. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | <input checked="" type="checkbox"/> NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Maryland | | | | U.S. | | WIDOWED | | <input type="checkbox"/> DIVORCED | | Baltimore City | | | | | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12. USUAL OCCUPATION | | 13. TYPE OF WORK (FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| Baltimore | | 1209 Wilcox Street | | Construction | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | |
| Maryland | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 2823 Hilldale Ave | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| Robert | | Rosenburg | | Mary | | Shuler | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| | | | | Mary Shuler | | 2823 Hilldale Ave | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Acute alcoholism | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 18 | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | | | | |
| | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | | | | | DATE SIGNED | | | | | |
| Margarita A. Korell | | | | Assistant | | | | | | | | 1-7-86 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | | | |
| Margarita A. Korell, M.D. | | | | 111 Penn Street | | | | | | | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | | | 1/11/86 | | | | King Mem. Park | | | | Baltimore Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| E.C. Phillips | | | | 1721 N. Monrovia | | | | JAN 10 1986 | | | | John Gordon | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH 17
(VR A15 ME (5))

1949

RECEIVED

LIBRARY

TO: DAD

FROM: [illegible]

SUBJECT: [illegible]

DATE: [illegible]

TIME: [illegible]

RE: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

020035

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director. Page 3 should be retained by the funeral director. Page 4 may be retained by the funeral director. Page 5 should be retained by the funeral director. Page 6 should be retained by the funeral director. Page 7 should be retained by the funeral director. Page 8 should be retained by the funeral director. Page 9 should be retained by the funeral director. Page 10 should be retained by the funeral director. Page 11 should be retained by the funeral director. Page 12 should be retained by the funeral director. Page 13 should be retained by the funeral director. Page 14 should be retained by the funeral director. Page 15 should be retained by the funeral director. Page 16 should be retained by the funeral director. Page 17 should be retained by the funeral director. Page 18 should be retained by the funeral director. Page 19 should be retained by the funeral director. Page 20 should be retained by the funeral director. Page 21 should be retained by the funeral director. Page 22 should be retained by the funeral director. Page 23 should be retained by the funeral director. Page 24 should be retained by the funeral director. Page 25 should be retained by the funeral director. Page 26 should be retained by the funeral director. Page 27 should be retained by the funeral director. Page 28 should be retained by the funeral director. Page 29 should be retained by the funeral director. Page 30 should be retained by the funeral director. Page 31 should be retained by the funeral director. Page 32 should be retained by the funeral director. Page 33 should be retained by the funeral director. Page 34 should be retained by the funeral director. Page 35 should be retained by the funeral director. 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Page 93 should be retained by the funeral director. Page 94 should be retained by the funeral director. Page 95 should be retained by the funeral director. Page 96 should be retained by the funeral director. Page 97 should be retained by the funeral director. Page 98 should be retained by the funeral director. Page 99 should be retained by the funeral director. Page 100 should be retained by the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|---|--|--|--|---|--|--|
| 1 - FOR STATE REGISTRAR | | | | | | | | | |
| REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JAMES A. SIMMONS | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1/ 14/ 1986 | | 2b. HOUR 4: 25 4M | | |
| 3 SEX M | | 4 RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR 5 4 36 | | 6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH USA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hutterman Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance Helper | | 12b. KIND OF BUSINESS OR INDUSTRY UNKNOWN | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN MD Baltimore | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 1929 W. North Ave 21217 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John M. Simmons | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Mae Garrett | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | |
| 16b. SOCIAL SECURITY NO. ? | | | 17. INFORMANT Ella M. Jackson | | | | 4126 Edmondson Ave | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTIC SHOCK DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. certify that (I) (this hospital) attended the deceased from 12/06 19 85, to 1/14 19 86 that (I) (we) last saw the deceased alive on 1/14 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Ludovino L. Cufeto | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/14/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) LUDOVINO L. CUFETO | | | | 22e. ADDRESS LUTHERAN HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/18/86 | | 23c. NAME OF CEMETERY OR CREMATORY Eastview Mem. Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR NAME Wm C March F. H West | | | | ADDRESS 4300 Wabash Ave | | 25a. DATE REC'D. BY REGISTRAR JAN 16 1986 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

BP



SECTION 2

WIND
SPEED
10
10

041099

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Jocan Simmons | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 27 86 | | | 2b. HOUR 9:15 AM | |
| 3. SEX FEMALE | | 4. RACE BLK | | 5. DATE OF BIRTH MONTH DAY YEAR 3 14 62 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GA. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH BALTO | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 922 Newington Ave | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House Keeper | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Balto | | | | 13b. COUNTY | | 13c. CITY OR TOWN City | |
| 14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nina Nix | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 220-14-1785A | | 17. INFORMANT ADDRESS Eugenia Johnson 922 Newington Ave | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiopulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF

(b)

Ischemic heart disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

Arteriosclerotic Cardiovascular

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-6-1980, to 12-15-1985, that (I) (we) lost saw the deceased other on 12-15-1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE [Signature] | | | | DEGREE | | 22c. DATE SIGNED 1-30-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. NAIR, M.D. | | | | 22e. ADDRESS 8810 York Road BALTIMORE 21212 | | | |

| | | | | | | | |
|---|--|----------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 3/01/86 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn | | 23d. LOCATION CITY OR TOWN STATE BALTO MD | |
| 24. FUNERAL DIRECTOR NAME Bailey-Douglas Funeral Home | | | | 25. DATE RECD BY REGISTRAR FEB 06 1986 | | | |
| ADDRESS 1348 Calhoun St | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

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ORIGINAL COLLECTED



020263

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

01567

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--------------------------------|--|-----------------|--|-------|--|------|--|------|--|----------|--|
| 1- DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| LOUISE | | | | | | SIMMONS | | JANUARY 14, 1986 | | | | | | | | | | 7:35 PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | | | | | | | |
| Female | | White | | 4 17 1896 | | 89 | | MONTHS | | DAYS | | HOURS | | MIN. | | | | | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | |
| Maryland | | U.S.A. | | | | Baltimore City | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | |
| Baltimore | | Church Hospital Corporation | | Self-Employed | | Grocery Store | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | | | | | | | | | |
| Maryland | | A.A. | | Baltimore | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 7950 Ft. Smallwood Road 21226 | | | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | |
| ===== | | ===== | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | | | |
| No | | 216-32-2650 | | James L. Newman | | Balto, Md 21224 | | 3338 E. Baltimore Street | | | | | | | | | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | | ASX ASPIRATION | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | DUE TO, OR AS A CONSEQUENCE OF (b) | | RESPIRATORY FAILURE | | | | | | | | | | | | | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF (c) | | SEPSIS | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | | | | | |
| | | P.M. | | 19 | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JANUARY 13, 1986, to JANUARY 14, 1986, that (I) (we) lost the deceased alive on JANUARY 14, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | | | | | | | | | | | | | |
| PEREDO, LUZVIMINDA K. M.D. | | | | | | 1/14/86 | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | |
| Burial | | 1/17/86 | | Holy Redeemer Cemetery | | Baltimore | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | |
| George J. Gonce | | JAN 16 1986 | | | | | | | | | | | | | | | | | |
| 4001 Ritchie Hwy Balto Md | | | | | | | | | | | | | | | | | | | |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

CONFIDENTIAL

NOTICE



[Faint, mostly illegible text covering the majority of the page, likely bleed-through from the reverse side.]

017130

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 2. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01568

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | |
|--|------------------|---|--|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Robert N. Simmons | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1/ 6/ 19 86 | | | 2b. HOUR 1:30 P | | |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 28, 1938 | 6. AGE (IN YEARS) LAST BIRTHDAY 47 YRS. | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1/ 9/ 19 86 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3002 Clifton Ave. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) City Parks | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Maryland | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Simmons | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Calloway | | | 16. SOCIAL SECURITY NO. 404-54-4443 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | | 16b. SOCIAL SECURITY NO. WW II | | | 17. INFORMANT Irene P. Simmons | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Hypertensive Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | 18. ADDRESS Drive 21215 | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? ABDO. ONLY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described. ABDO. ONLY Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accidents <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. | | | TITLE (SPECIFY) M.D. Assistant | | | DATE SIGNED 1/10/86 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1/17/86 | | 23c. NAME OF CEMETERY OR CREMATORY Garrison Forest | | 23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills, Md. | |
| 24. FUNERAL DIRECTOR NAME Leroy O. Dyett | | | ADDRESS 4600 Liberty Hghts. Ave. | | | 25a. DATE REC'D. BY REGISTRAR JAN 14 1986 | | 25b. REGISTRAR'S SIGNATURE Alvin Davidson-Rendell |

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

86 01569

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|--|--|--|---|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Louis Simon | | | 2a. DATE OF DEATH MONTH DAY YEAR 1/16/86 | | | 2b. HOUR 4:00 AM | | | |
| 3. SEX MALE | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR 9 14 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS. | | 7. UNDER 1 YEAR MONTHS DAYS 80 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) EXECUTIVE | | 12b. KIND OF BUSINESS OR INDUSTRY ENTERTAINMENT | |
| 13a. STATE MARYLAND | | 13b. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 2434 W. BELVEDERE AVE. 21215 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JULIUS SIMON | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH UNKNOWN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 089-14-6855 | | 17. INFORMANT MRS. BETTY JACOBSON 2280 BURNETT ST. BROOKLYN, NY 11229 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (R) lower lobe pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes mellitus | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/15 19 86 to 1/16 19 86 , that (I) (we) lost saw the deceased alive on 1/16 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE N. Brookins - Reddix | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 1/16/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) N. Brookins - Reddix | | | | 22e. ADDRESS Sinai Hospital, Baltimore | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL REMOVAL/BURIAL | | 23b. DATE JAN. 17, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY WELLWOOD | | 23d. LOCATION CITY OR TOWN COUNTY STATE PINELAWN NEW YORK | | | |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 22 1986 | | 25b. REGISTRAR'S SIGNATURE | | | |
| 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | | | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a necropsy performed.

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

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|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST CHARLES MIDDLE D. LAST SIMPSON <i>Charles D. Simpson</i> | | 2a. DATE OF DEATH MONTH 1 DAY 7 YEAR 86 | | 2b. HOUR 6:00AM | |
| 3. SEX male | 4. RACE white | 5. DATE OF BIRTH MONTH 1 DAY 10 YEAR 54 | | 6. AGE (IN YEARS LAST BIRTHDAY) 31 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed | |

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|---|--|--|---|---|---|
| 13a. STATE Md. | | 13b. COUNTY - | 13c. CITY OR TOWN Balto. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 331 E. 25th. 21218 |
| 14. FATHER'S NAME FIRST Charles MIDDLE P. LAST SIMPSON | | | 15. MOTHER'S MAIDEN NAME FIRST Patricia MIDDLE WAREHEIM LAST WAREHEIM | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 217-64-4467 | | 17. INFORMANT ADDRESS 1144 Montpelier St. 21218 Patricia Simpson (mother) | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) adult respiratory distress syndrome DUE TO, OR AS A CONSEQUENCE OF (c) - | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 45 minutes 24 hours |
|--|--|--|

| | | | |
|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) cadaveric renal transplant | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from January 7, 1986 , to January 7, 1986 , that (I) (we) last saw the deceased alive on January 7, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE Michele F. Nowotarsky, MD | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED January 7, 1986 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) michele F Nowotarsky MD | | 22e. ADDRESS Good Samaritan Hospital, Baltimore, MD 21239 | |

| | | | |
|--|-----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 1/11/86 | 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge | 23d. LOCATION CITY OR TOWN Baltimore COUNTY Md. STATE Md. |
| 24. FUNERAL DIRECTOR NAME SCHIMUNEK FUNERAL HOME, INC. | | 25a. DATE RECEIVED BY REGISTRAR JAN 10 1986 | |
| 3331 Brehms Lane, Balto. Md. 21213 | | 25b. REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR FUNERAL HOME: This law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove the following pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

